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ORIGINAL COMMUNICATIONS.

CHOLELITHIASIS WITH SPECIMEN.

By Clinton Cushing, M. D.

Read Before Medico-Chirurgical Society, May 7, 1900.

I herewith present 238 gall stones and with them the gall bladder that I removed from a patient two years ago last January. She was 32 years of age and had suffered from severe attacks of biliary colic for fifteen years. She had been treated almost continuously by different physicians with a variety of medicines but without material benefit. A dozen or more gall stones had been gathered from the fecal discharges following the attacks of pain. The paroxysms of pain had been well nigh intolerable requiring large doses of morphia for their relief. Aside from the attacks of pain and slight jaundice the health was good. With the gall stones in evidence and the history of the case before us there could be but little doubt that we had to deal with one of cholelithiasis, and since medical treatment had proved useless cholecystectomy was advised, and willingly acceded to. After free purgation and thorough bathing and scrubbing with green soap and hot water the operation was carried out as has already been described in my report of former cases. A free incision was made, parallel with and about one inch below the edge of the ribs on the right of the median line, and the existence of the gall bladder with the stones determined. The anterior edge of the liver was drawn up with a broad retractor, the cystic duct ligated with small chromicised catgut and the gall bladder removed. The abdominal wound was closed by through and through sutures of silk worm gut. The convalescence was uninterrupted, and now over two years after the operation she remains in perfect health and she has never since suffered pain. The scar on her side is scarcely noticeable.

The primary cause of gall stones is the existence in the body of an excess of cholesterin, and an excess of lime salts in the circulation. Now if there be added to these conditions a stagnation of the bile in the gall bladder and if there be also in the gall bladder foreign bodies which form a nidus for the formation of stone all needed elements and conditions are present. It is believed that cholesterin is produced by the retrometamorphosis of brain and nerve tissue and Austin Flint demonstrated that the veins leading from the brain contain more cholesterin than the arteries leading to it, but doubtless eating rich food to excess, and the free use of malt liquors and wines, particularly when coupled with a lack of bodily exercise tend to an accumulation and the non oxidation of the excrementitious material in the circulation. Those who suffer from gout and rheumatism are apparently more liable to suffer from cholelithiasis than persons who are free from these maladies. Among the foreign bodies that have been found in the center of gall stones I mention needles, minute blood clots and globules of mercury, bacteria and parasites of various kinds, and probably a small collection of epithelial cells might act as a nidus.

A most interesting article in this connection has recently been published in the Philadelphia Medical Journal. Typhoid affection of the gall bladder is probably nearly always present during the course of typhoid fever although it does not always manifest itself by any special disturbance. Chirari made a bacteriologic examination of the contents of the gall bladder in 22 cases of enteric fever and found typhoid bacilli present in 19 cases. Keen had collected 74 cases of this kind at the time of the publication of his book on, "The Sequel of Typhoid Fever." Camac raised the number of tabulated cases to 115 an increase of 41 cases in less than a year. The question arises, can typhoid affection alone independent of gall stones and other causes, produce pathological conditions. Keen has collected 34 cases in which empyema, cholelithiasis, or ulceration were present without any gall stones; it seemed to settle this question in the affirmative. A second interesting question is as to whether the typhoid bacilli of themselves give rise to gall stones. During the past two years several investigators have succeeded in producing gall stones by experimentally infecting the gall bladder, and it seems not unlikely that the typhoid bacilli are capable of such action. As early as 1889 Bernatim suggested that the bacilli might give rise to gall stones by causing stagnation of the bile, and Cushing of Johns Hopkins Hospital suggests that by clumping together the typhoid bacilli probably become the nucleus of stone. Let this be as it may it is certain that the bacilli have been found in gall stones sometimes many years after the occurrence of the fever. Cushing reports a case of cholelithiasis with gall stones and typhoid infection in which there was no history of typhoid fever either before or after the operation. This may also be considered a case of primary infection of the gall bladder. Robert T. Morris reports a case of typhoid fever with primary infection of the gall bladder. The patient was suddenly seized with pain over the gall bladder and on operating the peritoneum was found inflamed and the gall bladder much distended with mucus and pus. After the operation the patient passed through a typical course of typhoid fever of four weeks duration. Another matter of great interest is the length of time that the baccilli retain their vitality in the gall bladder. Von Dungern reports a case in which after various disorders, probably nearly all due to the typhoid bacillus, an abscess formed about the gall bladder and from the pus a pure culture of the typhoid bacillus was found 14½ years after the fever. Droba reports a case even more remarkable, in which he removed a greatly thickened gall bladder from a woman who had suffered from recurrent attacks from cholelithiasis for years. After the surface was sterilized with a glowing glass rod the gall bladder was opened with the sterile knife and from the pus pure culture of the typhoid bacilli was found 17 years after the attack of typhoid fever. Seventy-five per cent of all cases of cholelithiasis occur in women. One explanation for this frequency in women might be the pressure of the pregnant uterus upon the bile ducts and the wearing of tight corsets, both these causes tending to produce stagnation of the bile in the gall bladder. Then too as a rule, women do not take such active exercise as men, therefore the oxidation of excrementitious material is not as perfect. A partial stricture of the cystic duct or an acute or chronic inflammation of the bile ducts might easily act as a cause of the retention and the inspissation of bile might well be a cause of cholelithiasis. Gall stones are not infrequently found as an accompaniment of cancer of the liver. The pressure of the diseased parts upon the bile ducts probably acting as the cause of the stagnation of bile in the gall bladder. The number of stones vary greatly, from one to a thousand, under various shapes. Where only one stone exists it is usually symmetrical and may grow to be the size of a hen's egg. Where the number is very large as in the specimens here shown, some of the stones are not larger than grains of wheat. The most of them have small facets upon them caused by friction against each other while in the gall bladder.

Probably all stones are formed in the gall bladder and may remain there without symptoms. They may be found wedged in the ducts of the liver or a stricture of the cystic duct may exist with a distention of the gall bladder with mucus as a result of an inflammation, the walls being greatly thickened. Stones of large size have been known to ulcerate through the wall of the gall bladder into the peritoneal cavity or into the intestines, or cause the formation of an abscess which may open externally or into the lung. The symptoms which usually attract attention are caused by an effort on the part of the gall bladder to expel the stones. This results in very severe pain in the region of the gall bladder. As the stone moves down it causes intermittent and intolerable pain consequent upon distention of the bile ducts. So long as the stone remains in the cystic duct there is no obstruction to the flow of bile from the liver into the duodenum, but if the stone passes into the common duct and acts as an obstruction the bile is unable to escape into the intestine but is absorbed into the circulation producing pronounced jaundice, in addition to the pain. A moderate amount of jaundice occurs as a consequence of the stone passing through the cystic duct for the reason that the functions of the liver are more or less disturbed as a consequence of the pain and distress. The characteristic symptom of the passage of gall stones is the severe pain of a paroxysmal character in the region of the gall bladder unattended by fever, lasting sometimes for a number of hours, or two or three days, followed by a moderate degree of jaundice. Successive attacks would lead to the conclusion that the patient was suffering from cholelithiasis. Accompanying the pain there is usually nausea and vomiting and the patient is not always enabled to locate the exact point of the greatest suffering. The pain is frequently located in the pit of the stomach or in the region of the navel. If the paroxysmal pain is located in the region of the gall bladder and particularly if more than one attack has occurred the diagnosis may be comparatively easy. But if the gall bladder is sufficiently enlarged that it can be palpated and the abdominal walls are thin the diagnosis may be still easier. And if after a careful washing of the dissolved feces gall stones are found the diagnosis is positive. Many conditions exist which cause pain in the region of the stomach and liver. Ordinary intestinal colic, renal colic, psoas abscess, perityphlitis, hepatic neuralgia and malignant disease, all may cause pain of the regions about the liver and disturbed conditions of the stomach. The most important and typical symptoms are the paroxysmal colic, the slight jaundice, the vomiting and the discovery of the gall stones in the fecal discharges following the attack of pain.

A proportion of cases of cholelithiasis appear to be cured by medicines and treatment other than surgical. The treatment that appears to be the most satisfactory is a plan pursued at Carlsbad: the free use of the alkaline laxative waters, a diet of green vegetables, a moderate amount of meat and all the exercise that the patient can bear. No beer and very little light red wine. Laxatives of rhubarb, senna and blue mass when indicated.

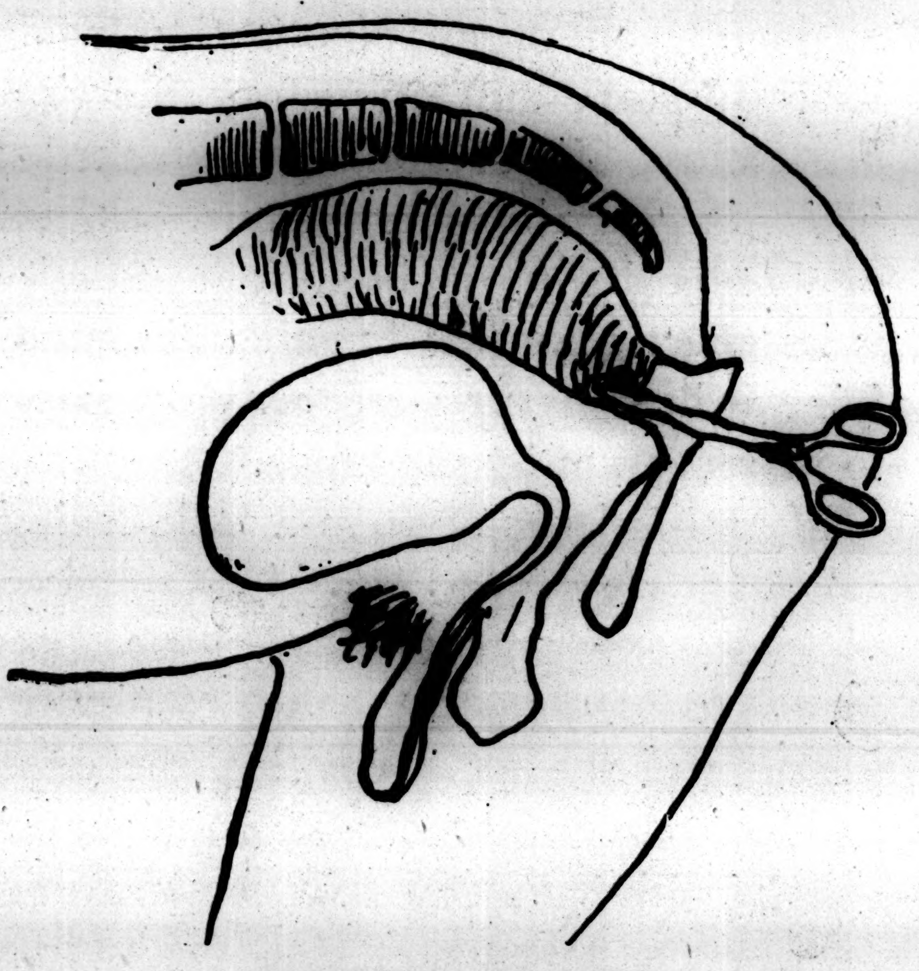
Manifestly if the cystic duct is narrowed or strictured, medical treatment must prove inefficient. If the stricture of the cystic duct is complete the gall bladder may become distended by mucus and in its effort to expel the contents causes severe pain. I removed such a gall bladder over two years ago. I reported the case at this society shortly after the operation. Within the past few weeks I learned from her physician in the North that she has since remained in excellent health. If the history of the case and the location of the pain point to the site of the gall bladder for the cause of the trouble the question of an exploratory incision might legitimately come up. If the health is seriously impaired by the suffering, or danger to life exists, I think the exploratory incision should be made and if a diseased gall bladder be found, whether it contains stones or not, the organ should be removed. If a patient is suffering from the attack of jaundice preceded by severe paroxysms of pain, the jaundice and pain not being relieved within ten days, an exploratory incision should be made particularly if it be a woman between 30 and 60 years of age, the most common period of life for cholelithiasis. If a stone is found impacted in the common duct it should be crushed with padded forceps, if it is a soft stone, and the fragments stripped down into the intestine. If the stone is hard the wall of the duct should be laid open and the stone shelled out, the cut edges of the duct being united with a continuous suture of fine catgut. As I have said in a former report I look upon the gall bladder as a useless appendage, precisely as we look upon the vermiform appendix. And cholecystotomy it appears to me would be as unreasonable in any disease of this organ as to lay open a diseased appendix and leave it in the abdomen. During operations on the liver or biliary passages, if a small amount of bile escapes on the peritoneum it should cause no apprehension. From my observation it does not appear to act as an irritant or a poison. Whether one would be warranted in opening the abdomen to relieve an acute attack of gall stone colic would depend on all the facts in the case; the length of time during which the pain continues, the probable existence of suppuration, the constitutional involvement, the temperature, etc. For the relief of the severe pain in an acute attack our main dependence should be upon the free use of hypordermic injections of morphia and upon anesthetics, and hot applications over the site of pain. Other symptoms being treated on general principles.

A NEW OPERATION FOR THE TREATMENT OF INTERNAL HEMORRHOIDS IN AMBULANT PATIENTS WITHOUT SPHINCTER DILATION OR ANESTHESIA.

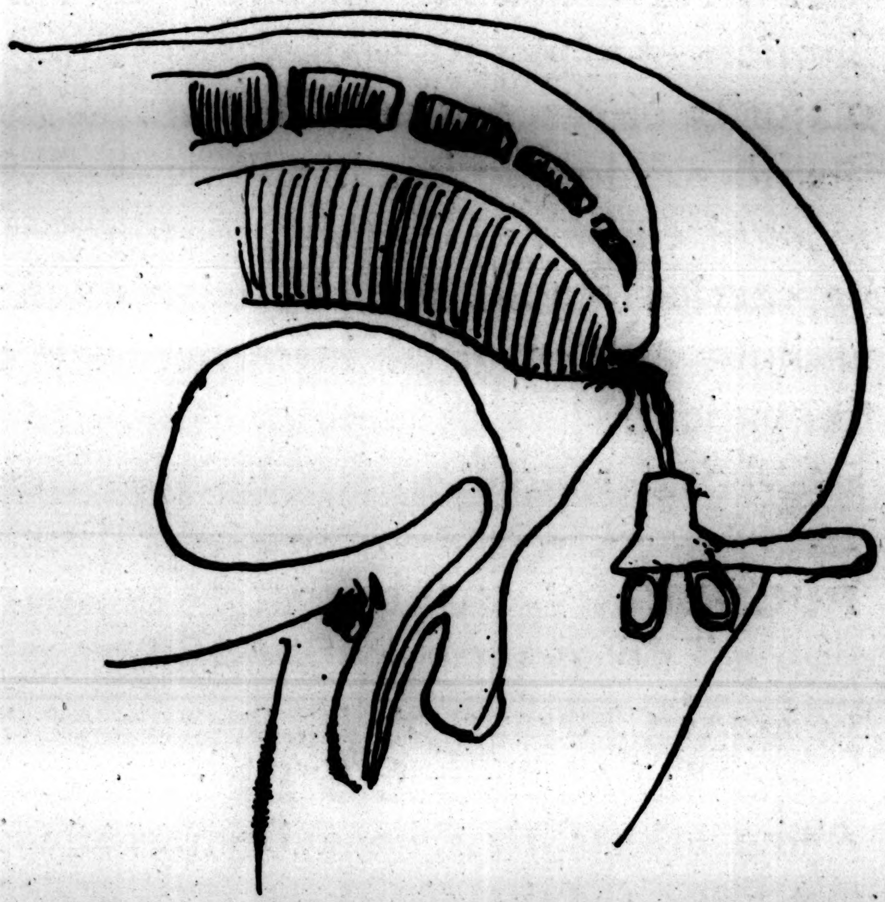
By Charles G. Levison, M. D. Chief of Surgical Clinic, Med. Dept. Univ. Cal., Adjunct Professor of Surgery Post Graduate Dept., Univ. Cal., and Consulting Surgeon to the California Eye and Ear Hospital, etc.

It is a well-known fact that there are many individuals who, while suffering acutely from internal ulcerating hemorrhoids, object to operation, giving as an excuse lack of time and dislike of the anesthesia. One in active practice meets with a number of patients of this class for whose relief the following operation was devised. There are many procedures suggested for the relief of this condition, but for the internal ulcerating bleeding pile, there are but few measures, mostly surgical, in general use.

When surgical methods are followed preliminary narcosis and dilation of the sphincter are absolutely necessary. The varix is then removed either by clamp and cautery or the ligature. There are two methods for treating ambulant patients of this class; the first, the injection method which consists in the use of chemicals, carbolic acid, iron or iodin, etc., which should never be resorted to on account of the well-known danger from embolism. The second, electrolysis is productive of some good results but it is slow and painful. Frequently the results are negative.



1.—FORCEPS GRASPING PILE.



2.—PILE RETRACTED BY FORCEPS AND SPECULUM.

The following operation, based upon purely surgical principles, while causing some pain, is practically a radical cure and can be carried out in one or two sittings. In the average case, there is usually one and seldom two varices, which cause most of the disturbance; and these can usually be treated in one sitting. The only pain experienced by the patient is when the pile is ligated; this can be done very quickly, so that the pain is of the shortest duration. There is no after effect, the patient going about as usual. No dilation of the sphincter or administration of an anesthetic is necessary. The only special apparatus required is the Kelly sphincteroscope, which should be included in the instrumentarium of every physician. This instrument is the only perfect speculum for inspecting the lower rectum. Every portion of the sphincteric region can be perfectly examined without reflected light and without subjecting the patient to any material inconvenience. This operation is carried out as follows: The patient is placed in the knee elbow position and the sphincteroscope is introduced, which permits thorough inspection. It is here, in the majority of cases, that the internal pile is found. After the localization of the pile or piles a piece of cotton saturated with a ten-per-cent cocain solution is applied for a few minutes; the cocain does not produce absolute anesthesia but it diminishes pain to such a degree that patients do not object. The pile is then grasped with a Pean hemostatic forceps and pulled down. Coincident with the drawing down of the pile the speculum is removed from the anus; it is allowed to hang on the handle of the hemostat and, possessing considerable weight, aids in drawing the pile somewhat further out of the anus. The pile is now extruding, held by the forceps, which are weighed down by the speculum; it is then ligated with a silk ligature as near the base as possible, after which the forceps and speculum are removed and the ligated pile is returned to the rectum. The patient's bowels must move daily; he experiences no inconvenience, going about as usual. The pile desicates and a practical cure results. If multiple varices are present the operation is repeated; but one sitting and the ligation of one group of varices in the majority of cases usually suffices. From the above description it will at once be recognized how easily this procedure can be carried out in the physician's office without any material inconvenience to the patient.

606 Sutter street.

PULMONARY TUBERCULOSIS AND THE NASAL PASSAGES.

By Louis C. Deane, M. D., Surgeon to the Cal. Eye and Ear Hospital, etc.

The efforts that have been made in past years for the discovery of a specific treatment for pulmonary tuberculosis have been varied and numerous. The hope and belief that something would surely appear to control the ravages of this disease have been stimulated by our successful and specific method of treatment of syphilis, which through the use of mercury seems to have lost many of its terrors. Since our efforts with cod-liver oil, creosote, tuberculin, etc., have not been followed by the marvelous results first accredited to them, our efforts seem to have turned to hygienic reforms, as prophylactic and curative measures. It has been often repeated that if there is a specific for tuberculosis of the lungs, it is fresh, pure air and plenty of it. Most of our hygienic measures must be said to be based on this principle. The use of breathing exercises, dumb-bell exercises, mountain climbing, and other athletic sports, sleeping out of doors, the removal to other climates where the air is clear and dry and warm, all have proven the value of pure air and plenty of it, as the most effective and conservative remedy we know of.

The proper care and treatment of the upper respiratory tract and nasal breathing, in such cases, is of the greatest importance. The nose is usually regarded as merely an organ of olfaction, while its respiratory and phonatory functions are almost, if not entirely disregarded. This is certainly erroneous, as undoubtedly its most important function is its effect upon the inspired air, modifying it in a marked degree, preparatory to its reception by the lungs.

My remarks may seem a little technical but if we stop to consider the physiological experiments that have been made to demonstrate the respiratory function of the nasal cavities, the effect on the lungs from a cessation or perversion of this function will be apparent. As Bosworth states: "On the normal functional activity of the nasal cavities depends the integrity of the whole of the mucous membrane of the respiratory tract below."

A function of the entire mucous membrane of the respiratory track is to secrete mucous but just in sufficient quantities to keep the membrane soft and pliable. In the pulmonary mucous membrane this condition makes possible the transmission of gases. Every breath of air that passes through the nasal chambers must become surcharged with moisture, so as not to inflict upon the pulmonary mucous membrane a deleterious effect by robbing it of its moisture and rendering its mucous thick and inspissated. The mucous membrane of the nose has, as a portion of its respiratory function, the throwing out of large quantities of water and we have in the nose an arrangement capable of furnishing this moisture in the form of the so-called, "erectile tissue" of the turbinated bodies. The watery constituents of the blood transudes and appears on the surface of the membrane. This is entirely separate from the mucous forming glands, and, to me, seems to be the most prominent function of the nasal mucous membrane, for while olfaction may be destroyed with but little inconvenience and no danger to health, an impairment of this function would involve a serious danger. Aschenbrandt's experiments in the Physiological Institute of Prof. Frick in Wurzburg on the moisture and temperature of exhaled air and the exclusive part the nasal membrane plays to produce these changes are exhaustive and conclusive. Each five litres of the air contains 2.77 grains of water, which constitutes complete saturation and the whole amount withdrawn from the body in twenty-four hours is 500 grammes or about 10 ounces, derived from the nose. A *second* portion of the respiratory function is the change in temperature the air undergoes in passing through the nose. The experiments of Aschenbrandt and Carter corroborated by Kayser, show that expired air has a temperature of 86°, which varies very slightly as compared to the varying temperature of the air before inhalation. This heat is derived almost exclusively from the nasal cavities. *Thirdly*: the air in inspiration is filtered of dust, etc. The larger particles are arrested by the small, moderately stiff hairs projecting from and within the anterior nares, the small particles are precipitated by the current of air and moisture on the nasal membrane. *In a word, the respiratory function of the nose is to temper, moisten, and free the air from mechanical irritation, so that it may pass over the delicate bronchial surfaces without injury to them.*

It might be said that the functions of the nasal cavities have a direct bearing upon all diseases of the lung, but I speak of them in relation to pulmonary tuberculosis on account of the chronic course of the latter and the reliance we place upon general hygienic measures and especially upon so called "pure air." Conditions that are most noticeable in hindering in their action, the respiratory functions of the nose are: 1. Stenosis of the nasal cavities, naso-pharynx and pharynx. 2. Diseases of the nasal cavities where the secretions are impaired and nutrition affected.

Among the most common causes of stenosis are enlarged turbinated bodies, deflected septums, polypi, adenoid vegetations and enlarged tonsils. The obstructions are to be removed with as little loss of tissue and impairment of the normal mucous membrane as possible.

Under the heading of diseases, we have all the catarrhal affections where the secretions are either increased or decreased in quantity. The remedy for this condition is not, as many physicians suppose "an alkaline spray," it is a mucous membrane, as in other parts, and it responds well to the proper and local application of remedies. I have heard in this and other societies, learned discussions upon the merits of certain applications to the mucous membrane of the urethra, vagina, uterus, pharynx, larynx, etc., and it is certain that each physician has the choice of a number of remedies for varying conditions of these membranes, while, I have found that most content themselves with merely a cleansing alkaline spray for the nasal cavities. One of the most trying diseases of the nose associated with pulmonary tubercular tendencies is atrophic rhinitis. In this we have all the nasal functions perverted except that the patient can breathe readily through the nose, and this fact is often misleading; there are points of decomposition with innumerable bacilli. The proper treatment of this condition to restore the respiratory function comes within the sphere of the specialist, to stimulate the circulation, render the parched and desiccated mucous membrane moist and remove the foci of decomposition.

THE PLAGUE—CASES FOURTEEN AND FIFTEEN.

By W. H. Kellogg, Bacteriologist to the Board of Health.

William Murphy, aged 34 years, male, Caucasian. Occupation, clerk. Born in California. Residence 427 Dupont Street between Bush and Pine. The patient rode out to the Hospital in a car and was admitted to Ward C. The following history of the case was taken from the records of the City and County Hospital.

Habits.—He has smoked opium and used morphine hypodermically for the last nine years.

Past history.—Chills and fever seven or eight years ago and was also treated in this Hospital for pain in the side and discharged cured in three or four days. No venereal history; constipated for the last nine years.

Present illness.—Last Tuesday afternoon (Aug. 7th) he noticed a pain and slight swelling in the right groin. That evening he began to feel sick and sore all over, had some headache and vomited a small amount of bitter greenish substance.

Examination. — Heart slightly enlarged to the right. Lungs dull in axilla and diminished resonance over both apices, anterior and posterior. Sibilant and sonorous rales over both lungs.

Abdomen, reflexes and sensation normal. Urine, specific gravity 1020; albumen 1/30 per cent, no sugar. Microscopical examination, phosphatic crystalis and some pus cells.

The temperature chart show the range of temperature to have been from normal to 100°. Pulse, 100.

A painful bubo was present in the right femoral region.

The patient died August 11th at 8:20 A. M.. Duration of illness five days.

Autopsy, performed August 11th, by Prof. Taylor of the Medical Department of the University of California.

Autopsy (Hospital record).—Body of a well nourished man, apparently thirty years old. The face, neck and extremities are livid. The entire surface of the arms is covered with small scars. Rigor mortis moderate in degree. On section the tissues are bloody; panniculus adiposus is exceptionally thick. Peritoneum covering intestines is injected; intestines present several dark patches suggestive of hemorrhages. No effusions.

Thoracic muscles deep red color. Diaphragm on right side extends to fifth rib, on left side to fourth. Both pleural cavities, numerous adhesions. No exudate.

Pericardium contains an excess of clear fluid. Heart and great vessels filled with heavy post mortem clots, weight of heart 410 grams. Walls one-half thicker than normal. Muscle deep red. Aortic valves soft, elastic and competent. Aorta, few patches of atheroma. Aortic orifice enlarged admitting three fingers. Mitral valve slightly sclerotic.

Lungs right, crepitant throughout; exudes frothy serum on section and pressure. The bronchi contain pus. Up to the third ramification of the bronchial tubes they contain no hemorrhages and no free blood. Bronchial glands are not enlarged. Left lung.—Deeply congested in lower lobe and presents a gelatinous feel and appearance suggestive of disseminated tuberculosis; otherwise like right.

Mesentery has a mottled appearance: glands not enlarged.

Common bile duct pervious.

Stomach.—A tremendous injection and submucous hemorrhage. Not dilated, mucous membrane smooth, no ulcers.

Spleen.—Weight 615 grams, deeply congested, very friable.

Duodenum, slightly injected; no free blood in stomach.

Pancreas.—An extensive hemorrhage into the tissues about the pancreas and behind the lesser peritoneum. Extensive hemorrhages into the substance of the pancreas. No fatty necrosis.

Liver bound down by posterior adhesions. Weight 2330 grams. Extends below the level of the umbilicus. Increased in antero-posterior diameter. On section, pale; somewhat resistent to knife and of fibrous appearance.

Gall bladder not enlarged, contains one ounce of dark colored bile and two gall stones. No obstruction in common duct.

Intestines Mucous membrane congested. Numerous sub-mucous hemorrhages. No ulcers.

In right groin are two enlarged lymph glands, hemorrhagic but not purulent. An enlargement of the glands in the right femoral regions.

Dr. Taylor left intact the bubo in the right femoral region for bacteriological examination by myself and others.

The next day in the company of Drs. Kinyoun, Ryfkogel and Pillsbury I removed the glands from the bubo and found them necrotic, full of hemorrhages and larger than in any previous case. Microscopical examination of the glandular tissue and spleen showed the plague bacilli, typical in form and in much larger numbers than usual. Guinea pigs were inoculated and died of typical infection. Other guinea pigs have been inoculated with pure cultures obtained from the glands and spleen.

CASE NO. 15.

Ham Tan, Chinese, male, aged 29 years, residence 900 Dupont Street, died August 15th at 9 P. M. He had been treated by a white physician, who has a large practice among the Chinese and who reported that the death was due to phlegmonous erysipelas and septic pneumonia. I saw the case August 16th and found an enlargement of submaxillary glands on the left side, which I removed and found to contain the plague bacillus in large numbers. Guinea pigs were inoculated with emulsions made from the gland and died with typical lesions of plague. Pure cultures have also been obtained from the gland. An autopsy of the Chinaman showed nothing aside from what could be expected in cases of plague. The heart was soft and flabby and valves normal. Decomposition was well advanced and all the cavities were distended with gas. The lungs were much congested but no consolidation. Vessels of the mesentery injected. Spleen enlarged, very dark and soft. No enlargement of the lymph nodes.

NOTES ON THE THERAPY OF GONORRHEAL URETHRITIS.

By J. C. SPENCER, M. D.

Read before the San Francisco County Medical Society May, 1900.

It is with some hesitation that I venture to submit the results of my personal experience in a field so well threshed. Each of us is prone to follow the methods which have yielded the best results for him, those with which he has grown familiar. I have no novelties to offer either as to remedial agents or methods.

The diagnosis having been established with the microscope, it is my custom to begin treatment at once. I have found no advantage in delay, and no evil results from immediate treatment. The ideal first step, comparatively rarely attainable, is complete rest in bed. This affords an easy method of controlling the patient's mode of life and hygiene. With the best intentions, a gonorrheic patient will commit greater or smaller indiscretions unfavorable to the course of his disease, hence the converse is true when he is confined to bed. A reasonable patient of leisure will usually find this no hardship. The vast majority of patients, however, must be treated as ambulants, owing to various exigencies. Excesses in venere are almost sure to be accompanied by excesses in baccho, hence the gonorrheic usually presents himself with gastro-intestinal and hepatic functions more or less disturbed. A mercurial followed by a saline forms a preliminary routine in practically all cases, continuing with a mild saline at judicious intervals during the course of the disease. My experience with methods of abortive treatment has been confined to the use of 5 and 10 per cent solutions of silver nitrate only to be irrevocably relegated to desuetude. The results I have obtained have made me content to abide by the somewhat slower methods of treatment. I read a report several years ago of a certain army officer, whose indiscreet excursion into the relms of Venus on the eve of his intended marriage brought him to the post surgeon with a urethral discharge. I do not recall that a diagnosis of gonorrhea was made by microscope. The urethra was injected a few times with peroxide of hydrogen, and the patient regarded as cured. As this case is reported from memory, my data may not be entirely accurate, but I must confess myself as somewhat sceptical as to the correctness of the diagnosis in the first instance. It is superfluous to say that I have not used the above form of abortive treatment. Since the specific for which we are all waiting has not as yet materialized, and we have a formidable array of remedial agents from which to select suitable ones, the choice must depend on the experience of the practitioner. The prime object to be attained is the speedy destruction and eradication of the gonococci. The general consensus seems to be that some salt of silver is most efficacious. Although an invaluable aid under certain conditions the nitrate is not indicated in acute urethritis, principally because of the formation of the chloride, when in contact with body fluid and the coagulation of albuminous matter which it produces. Some soluble albuminous combination seeming to be the desideratum, a salt known as protargol has been evolved. It is my practice to begin with a solution of ¼ per cent in strength and feeling the way along as to the tolerance of the patient's urethra, increase the strength at intervals of four or five days if need be until 1 per cent or even 2 per cent is reached. The limit is governed by the disappearance of gonococci. The majority of cases show a disappearance of the latter in from four to seven days by the use of a 1 per cent solution. Most urethras tolerate the solution of protargol well. Following Neisser's method it is my custom to instruct the patient to inject three times a day, urinating each time immediately before; to adjust an object, so as to make firm pressure on the perineal region, just in front of a line between the ischial tuberosities. The fluid is retained ten minutes at the morning and mid-day injections; for three consecutive periods of ten minutes each at the night sitting. The last injection is regarded irksome, and justly, but none the less, I insist upon it. Coincidently, I prescribe a urinary antiseptic, such as urotropin or cystogen, either of which is administered with abundance of water. Because of the convenient tablet form, I usually order the latter, giving a 5-grain tablet with a glass of water three times a day. The chief disinfectant element in this as in urotropin is formaldehyde. The shape of the syringe nozzle I regard as important. It is my habit to have the little teat-like projection on the ordinary urethral syringe with a soft red rubber tip, smoothed off, so that practically the most prominent part of the convexity of the now acorn shaped tip, is placed against the separated lips of the meatus and the fluid about 10 cu. ctm. in amount. slowly injected. In the case of an unusually small meatus it is sometimes necessary to use a very shallow conical pointed instrument. In any event I leave none of the technical details to the fancy of the patient, making him understand clearly how I wish each detail carried out. Some anterior urethras have not a capacity sufficient for 10 cu. ctm. of fluid. This may only be determined empirically. The patient holds his urine for at least two hours before appearing at the office and then urinates in two glasses, the gross appearance of the urine giving certain evidences with which every urologist, sooner or later becomes familiar, thus yielding corroborative evidence of the conditions in the urethra. The secretion presenting at the meatus before urination is examined every day or at least every other day, in order to control the relative number of gonococci. During the first week or ten days corresponding to the acute or ascending stage of the disease the microscope usually reveals a preponderance of leucocytes, many of course, containing enclosures of the typical diplococci of Neisser. Very few epithelial cells are evident, as the gonococci begin to diminish however and the acuter symptoms to subside, the leucocytes diminish in number, and many large round or oval epithelioid cells become evident. Taken in conjunction with the improvement in other respects, I am prone to regard the appearance of these large epithelioid cells as evidences of a diminution of the process, in fact of a beginning healing. To me they are an evidence of an active desquamation of the superficial layers of the mucosa, and ipso facto of a throwing out of the gonococci from the deeper layers. These particular cells I regard as a surplus in the supply of new cells provided by nature to take place of the destroyed epithelia. I find that as a rule the patients complain of little or no irritation during or after the use of protargol injections, excepting perhaps the one at night. This may be accompanied by a little burning at the time of the second and third injections, and perhaps a little burning upon the first micturition subsequently. It is my custom to instruct the patient not to inject immediately before retiring because of the possibility of producing annoying if not painful results. I have yet to find a patient whose urethra would not tolerate the—for him—proper strength of protargol solution. After the lapse of about ten days or two weeks when the more acute symptoms have subsided, and the gonococci are no longer discoverable, it is my custom to lay aside protargol and resort to argonin, silver casein, which continues the gonococcicidal action, but possesses a decidedly more astringent action than protargol. The argonin solutions are slightly more irritating than those of protargol, and should be proportionally weaker. The argonin is continued for from three to six days and while still carefully controlling the intra urethral conditions by inspection of the urine and examination of the discharge, if any present itself at the meatus, or of the "clap-threads," so-called, I prescribe a simple antiseptic, astringent solution composed of mineral astringent salts such as zinc and alum, or lead acetate, or if not well borne, an equally mild vegetable astringent. It is at this stage and during the short period preceding that the pus cells are prone to become very scanty, the epithelioid cells, equally so, and much mucus to appear. The astringent treatment is continued for about one week, and then a halt is called in active local treatment. I continue the cystogen or urotropin, and caution the patient to continue to observe an equally careful dietetic and physical regimen. If there be no tinge to the moisture appearing at the meatus, if there are no, or few slight threads in the first portion of urine, and no gonococci are discoverable, and these conditions are still present after the lapse of a week, I am prone to consider my patient cured. If at the cessation of active local treatment there should develop a sense of uneasiness, itching and stinging along the urethra, with a reappearance of the discharge, the microscope is my criterion as to the true cause of the renewed disturbance. If gonococci reappear protargol treatment is immediately resumed. My experience has been that there is a much more rapid subsidence of the acute symptoms following such a relapse than that following its use at the outset.

The foregoing refers only to uncomplicated gonorrheal urethritis of the anterior urethra occurring in private practice. At the clinic we are in the habit of using zinc permangate. Latterly I have been trying mercural but as yet have not tested its efficacy sufficiently to warrant me in more than its mention. Occasionally a case at the clinic is treated with methylene blue and boric acid in capsule, combined with powdered nutmeg or oil of nutmeg as a carminative. As I do not depend on this alone, but always prescribe it in conjunction with local treatment I cannot give any results as to its efficacy. The Janet method of irrigation with potassium permangate has not yielded satisfactory results in my hands and I have ceased to use it for acute urethritis. The patient usually learns by imitation and through intense personal interest to inspect his urine for the presence of "clap threads" and toward the latter part of the course of his disease, to strip the urethra upon arising, for the depressing "morning drop." Because of the pernicious moral effect of both practices, I am quick to insist, that he shall indulge in neither, explaining that owing to his limited knowledge of the nature, and course of the disease, he is not a competent judge as to his condition. I also impress upon the patient at the outset, that he is suffering from a disease fraught with almost numberless very serious possibilities, and continue to keep him mindful of the same during its course. I consider that each of us should regard himself a missionary, one of whose chief duties is to neutralize and change the popular, flippant ideas prevalent with regard to gonorrhea. If we are a unit in our views as to the serious possibilities resulting from gonorrheal infection, the time must come, sooner or later, when the lay male public will become properly educated on this subject and use some form of prophylaxis against infection.

The foregoing is a brief resume of my own methods in the treatment of uncomplicated acute gonorrheal urethritis of the anterior urethra. Because of the vastness of the entire subject of gonor-

property of and must not be
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rheal infection in all its phases and possibilities I have deemed it wise to confine myself to what may be considered the borderland.

AN APPLICATION FOR TREATMENT OF FRACTURED CLAVICLE AND FOR DISLOCATION OF ACROMIAL END OF SAME.

By S. C. Gibson, M. D., Reno, Nev.

While a student of the School of Mines at Rolla, Missouri, I saw the lamented Doctor Glenn apply the following described dressing to a fracture of the clavicle and I have successfully treated many cases by this method since I entered the profession in 1879.

The following is a description of the splint with photographs of the patient before and under treatment.

Figure 1 represents the appliance, which consists of two parts—the splint and the cross-belt, which hold the splint in position. The splint resembles the arm-piece with a part of the staff of an ordinary crutch, and is made of any light wood half an inch in thickness. The belt may be made of leather, webbing or even heavy muslin. The dimensions suitable for the average adult should be five and one-half inches across the arm-piece, inside measurement. The staff should be about ten inches long, and tapering at the lower end to fit the pocket in the belt. From three to three and a half inches from the hollow of the arm-piece are two mortises, each two inches long by one-quarter inch wide, near the edge of the staff. Use a belt long enough to pass around the arm and through the mortise holes. This arm-belt is to confine the arm to the splint and prevent motion. The cross-belt, which supports the splint in situ, is two inches wide and from fifty to fifty-six inches long with the part including the pocket. This pocket is formed by folding the belt half a turn and then confining the pocket by stitching or riveting. The pocket is intended to receive the lower end of the staff. The appliance is simple and can be easily adjusted. The fracture having been reduced and while the arm is being supported the arm-piece of the splint well-padded with cotton, retained, if necessary, by a few turns of a roller bandage. Then it is slipped into the axilla and the pocket of the cross-belt over the end of the splint and the ends of the cross-belt are passed over the sound shoulder buckled moderately tight, until the two fragments are in apposition. Under the cross-belt, where it passes over the shoulder, a pledget of cotton may be placed to prevent chaffing. The humerus is then pressed gently to the splint and confined by the arm-piece, and, if thought necessary, a few turns of a bandage around the chest over the humerus. The forearm is now supported by a sling and the dressing is complete. The size of the splint may be modified to suit conditions. For a small adult a smaller splint may be used and a still smaller with a narrower belt for children. In case of emergency it would be easy to improvise a splint made of a piece of clap-board.

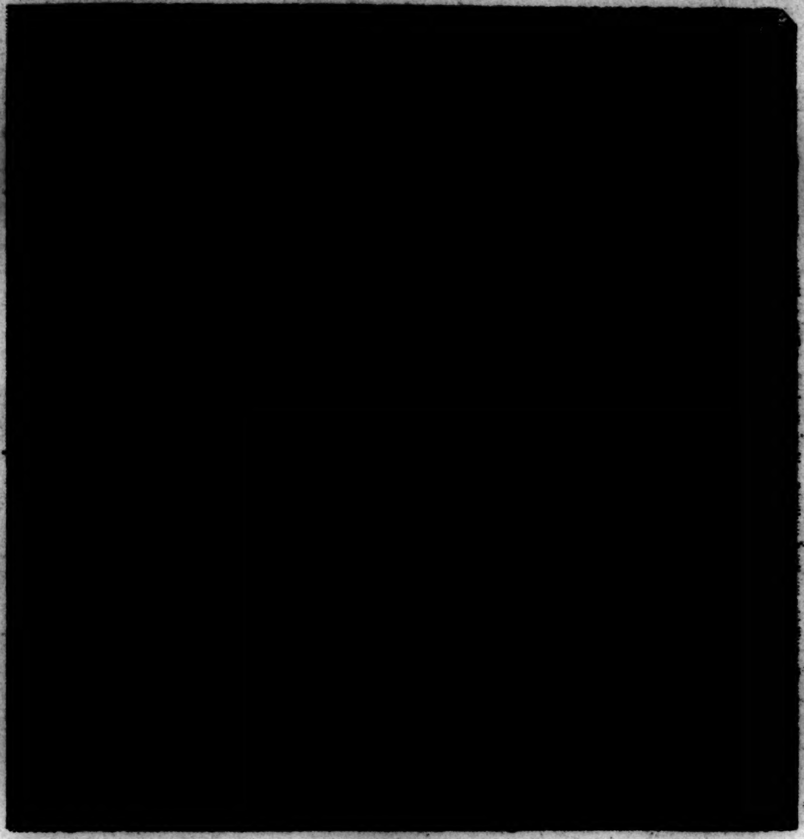

Fig. 1.

Fig. 2 shows a case of fracture before the appliance is applied.

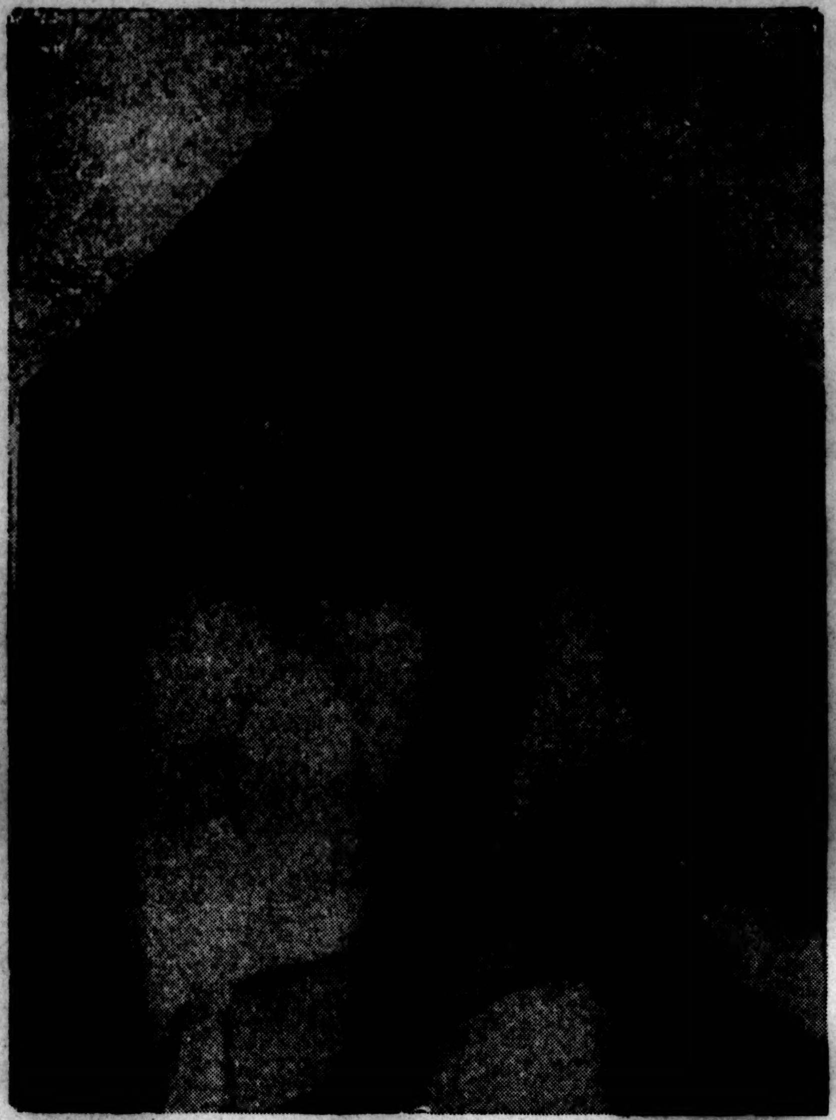

FIG. 2.

Fig. 3 shows the same patient with the appliance in place with the sling omitted.

I have successfully treated by this method many cases of fractured clavicle during my twenty years of practice. I have also successfully treated by the above method two cases of dislocation of the acromial end of the clavicle. The cases thus treated varied in age from the tender years of childhood to old age. I claim for this appliance simplicity, economy and comfort at the same time the fractured bone is secure against displacement.

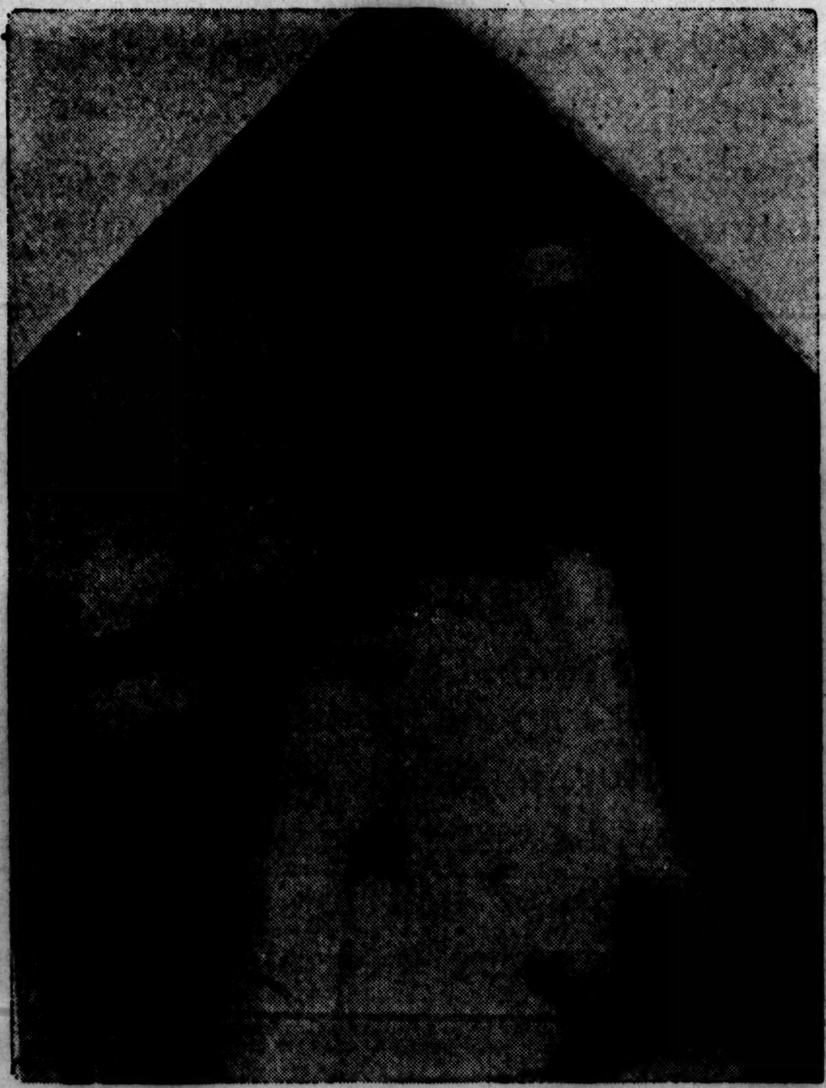

FIG. 3.

MILK.

By A. B. COWAN, M. D., Fresno.

Read at meeting of the San Joaquin Valley Medical Society, Fresno, March 13, 1900.

It is with a feeling, somewhat akin to apology, that I offer for your consideration the time-honored subject of "Milk," and in submitting this paper I wish to make no claims whatever to originality in its substance.

Nutrition in its broadest sense is the most important branch of pediatrics, and I have assumed milk to be, pediatrically speaking, synonymous with nutrition containing, as it does, all the elements in a proper proportion for the normal and healthy development of the child, and the importance of correct ideas concerning this theme can hardly be over-estimated.

In this paper I shall confine myself to the subject of maternal feeding. This theme is becoming more important every day, for it is at this period of life that prophylaxis gives us our best results, this consisting almost entirely in the proper feeding of the baby. It is not simply a question of adopting some food that will carry the baby through the perilous first year of its life, but to launch the young being symmetrically, so that it will grow into healthy manhood or womanhood, not handicapped by deranged tissues and organs, rickets, scurvy, indigestion, the result of an erroneous diet. This question of whether a child shall grow to be strong and robust or a weakling is often decided by its food during the first three months of its existence. When we consider that 20 per cent die during the first year and that a vast majority of deaths are caused directly and indirectly by improper alimentation, and, when we consider also that the mortality rate is increasing, rather than diminishing, we can get some idea of the vast importance of correct feeding. It is generally admitted that breast milk is the food par excellence for babies, hence it becomes our solemn duty to use our best endeavors to keep the baby on the maternal nursing ground; but, in these latter days, it is astonishing to note with what frequency motherhood is accompanied with the inability or disinclination to suckle the young at the maternal fount. Indubitably there are many instances where it is absolutely imperative to put the baby upon artificial food, but it is equally true that in many instances the infant is deprived of the breast milk without sufficient reason, either by the mother herself, or, I am sorry to say, by the physician in charge. At other times the baby is weaned through the solicitations of the neighbors, friends or relatives. From whatever cause it is not an infrequent and unjustifiable occurrence. We are called to a case and we observe that the baby does not thrive on its mother's milk. The baby does not gain and perhaps loses in weight. It may be bloated and colicky, suffering with indigestion. It vomits its food and is anemic. It is fretful, cries continuously, does not sleep, etc. It is in such cases that we are too apt to inform the mother that her milk does not agree with the child and proceed to put the baby on artificial food, an error, the effects of which are often manifest throughout after years or may cost a child its life. What is the reason milk disagrees? Is there not some way to correct it? Is it absolutely impossible to remedy it so as to make it properly fulfill the purpose of nourishing the child? These are questions we should ask ourselves in every instance, and these are questions, which I am sure are oftentimes overlooked.

In other instances it is the mother alone, who through disinclination, without consulting the family physician, takes the baby from the breast. She, perhaps, argues that the duty she owes to society will not permit of her nursing the child, and of her own accord lays in a stock of bottles, nipples and some artificial food. The baby worries her; she does not want to nurse it if the bottle is less trouble. Nursing makes her fretful, she pouts, she worries and when the little fellow, as an evidence of the immense satisfaction he is receiving, returning thanks as it were in his own cute little way, grabs, bites and tugs at his mamma's fissured nipple, she flies into a passion, and forthwith proceeds to purchase one of those rubber infringements upon God's patent nipple. This is not an overdrawn case. During my short professional career it has happened time and again and it is in just such cases that it lies in the province and power of the physician to do much good, provided that we are consulted before the bottle has been adopted. As stated above 20 per cent of the children die during their first year, and a vast majority of this number from the effects of malnutrition. The mortality rate is on the increase, especially in the large cities, partly the result of overcrowding, unhygenic conditions, etc., but mainly because the number of mothers who do not nurse their children is on the increase. Dr. Emmet Holt states that in his private practice the number of mothers who nurse their children is about one-third. In many of these cases the mother refuses absolutely to give the baby the breast milk. She cannot be persuaded to nurse the little one and our attempts are futile, but in many other cases, if we would use our utmost endeavors; if we would show to these mothers the importance and necessity of nursing their babies; if we would impart to them a knowledge of the injurious effects attending artificial feeding and the liability of an early death, directly from malnutrition or indirectly from some intercurrent disease; if we would inform them of the probability of their children being weaklings, I am certain that the number of mothers willing to nurse their babies would be increased. Now, to return to the mother who worries and frets: Before concluding to wean the child, let us use our endeavors to correct the milk so that it will agree with the baby. Let us not be hasty in withdrawing the breast. It is known that an emotional state of mind exercises a great influence over the secretion of milk. In just what this change consists is not fully understood, but it is probable that there is some chemical change in the proteids of the milk. It is our duty in such cases to endeavor to correct the maternal state of mind. We should labor earnestly and patiently with that mother. We should reason with her and tell her why her milk is disagreeing with the child. Why it fails to nourish, causes vomiting, diarrhœa, etc. We should do our utmost to bring about a peaceful and contented frame of mind. That it is more easily accomplished than it seems, I have reason to believe from past experience. I have succeeded not once, but many times in persuading the mother to nurse the child, and in one instance, in particular, a good, plain, straightforward talk to the mother undoubtedly saved the little one's life. In this case the mother was given to fits of despondency, and, at times, passion. The emotions had wrought such a change in the milk that the baby was lying at the point of death. The child had lost its baby features, the eyes were sunken, the fontanelles depressed, the subcutaneous fat had been absorbed, leaving the flesh, hanging loosely from the long bones, the skin was dry and wrinkled, lines formed round its mouth, Iadelot's smiling parenthesis, the fresh rosy complexion faded to a dull yellow tint, in a word, the child was about as near the grave as was consistent with life. Fortunately, in this case, I was acquainted with the mother's temperament, I plainly informed her of the cause, that it was her everlasting bad humor, and I am not so sure that I did not say something about murder. At any rate, and this is the point I wish to bring out, the change in the mother and the consequent change in the milk worked marvels. The effect was an immediate and most striking improvement in the child, bringing it back to roseate health in a few months. A little domestic history of our patients, although sometimes unpleasant and tiresome to us frequently results in much good. Since that time I have had other cases to attest the efficacy of psychical treatment upon the production of and character of milk, and always with the greatest of satisfaction. I shall continue its use.

There is another class of cases, in which a knowledge of the composition of milk and a simple method of examining will do much good. In this class the mother is perfectly willing to nurse her baby, but for some reason the milk disagrees, causing colic, vomiting, indigestion, and the child does not thrive. Here again we are wont to replace the breast by artificial food, when if we would but study the case a little more closely we might determine the underlying cause for the trouble. It is in these cases that an examination of the milk often reveals the trouble, and the remedy is simple. Indeed, I am becoming so enthusiastic over the examination of milk that I think it a wise idea to do this in almost every instance; where the nursing child has some indisposition, or bowel trouble, we might attribute it to "teething" and give the child medicine when the fault lies entirely with the mother. Let the lactometer take its place alongside the urinometer. First we will begin with a knowledge of what constitutes normal milk. What are the physical characters, the ingredients and their proportions? According to the consensus of opinion of authorities human milk is a secretion of the mammary glands of a bluish, white color and quite sweet to the taste. It is of an alkaline reaction, rarely neutral, never acid under normal conditions, and its average specific gravity is given at 1031. It consists of the following elements: Fat, 4 per cent; proteids casein and lactalbumin 1½ per cent; sugar, 7 per cent; mineral salts, 2-10 to 1 per cent; water, 87 3-10 per cent. The percentages of the ingredients may depart from this standard to some extent and still be a healthy variation, but any great departure will bring about deleterious results. The fat and the proteids are the great varying elements, the sugar and mineral salts remaining singularly constant, so much so, in fact, that in the examination their presence can be ignored. Bearing these facts in mind, by means of the breast-pump, we obtain a sample of the milk that is causing the disturbance. In order to get an average sample it is better to strip one breast entirely. With our sample we first determine the reaction by means of a piece of litmus paper. Next we take the specific gravity by means of a small hydrometer. An ordinary urinometer will serve the purpose, provided there is sufficient fluid to float it. Having learned the specific gravity we make a note of it for future use. Now as to the examination of the fats, and it is the element, more than any other, that gives the widest and most frequent variation, with a cream gauge, an ordinary glass cylinder such as is used in taking the specific gravity of urine, only smaller and divided into one hundred equi-distant marks, will answer every purpose. A 10 cc. tube with each cm. divided into ten parts is the gauge ordinarily used in rough examination. With our freshly drawn sample we fill this tube with exactly ten cc. of milk, if necessary, using a pipette to insure accuracy. We cork the tube tightly and set it away undisturbed at the ordinary temperature of the room, 70° F. for twenty-four hours. At the end of this time the cream will have risen and we can readily determine the percentage by looking at the gauge. There is a general misapprehension concerning the composition of cream. It is often spoken of as something entirely different from milk, when, as a matter of fact, it should be considered as milk containing an excess of fat. The proportion of the other ingredients is not very much less than in ordinary unskimmed milk. The proportion of fat to cream is about as three is to five, that is three-fifths of the cream in our gauge is fat, for instance, if we find on consulting the gauge that the percentage of cream is six per cent, we would have the following proportion 5:3::6: the amount of fat in our sample of milk, which in this case would be 3⅗ per cent, a practically normal amount. Having learned, by examination, the amount of fat it is our next duty to determine the percentage of proteids, and while the method I propose is one of estimation rather than of accuracy, it is often of very great value, and, if there is any great variation, it can easily be determined. We have already regarded the sugar and salts as being so nearly constant, as not to affect the specific gravity and having learned the specific gravity and the amount of fat it is easy to determine approximately whether the proteids are greatly increased or markedly diminished. We must remember that the fat tends to lower, while the proteids raise the specific gravity. To apply this principle: if the specific gravity is low, say 1027 and upon examination we find the amount of fat to be high, 10 per cent, we would consider the milk nearly normal in proteids, because it is the excess of fat that lowers the specific gravity. Now if we find the same specific gravity 1027 and a normal percentage of fat, we would assume the proteids to be very scanty and that it is very poor milk. Again if with the specific gravity of 1032 or over, with a large percentage of fat say 6-7 or 8 per cent, it must be very rich in proteids, otherwise the large amount of fat would have lowered the specific gravity. Taking the specific gravity as 1034 and the fat at 1½ or 2 per cent it is safe to predict the proteids are nearly normal, perhaps slightly in excess. In this case it is not the proteids that raise the specific gravity, but a lack of fat. These rules seem at first glance to be complicated, but in reality they are very simple, if we will but bear in mind high proteids, high specific gravity, high fats, low specific gravity. These methods, as given above, may seem a trifle crude and imperfect, but they are really of great value. They are simple and comparatively accurate. By all means let us examine the milk and then we are on a footing to treat the case on a rational basis and in many instances our efforts will be followed by the most happy results and the improvement in the child will give us a great amount of personal gratification and earn the everlasting thanks of the mother.

A few words as to the practical application of the knowledge we have gained by the examination. We may and often do find the proteids greatly in excess a frequent cause of indigestion. This will be our advice to the mother: Take plenty of exercise in the open air, even to the point of exhaustion, nurse the child less frequently as it has been found that the longer the milk remains in the breast the more watery it becomes. Restrict the amount of solid food and increase the amount of fluids. If there is an abundance of milk we will advise her to draw off a certain amount from each breast before nursing the child, as the first part of the milk contains more proteids and less fat than the latter portion and vice versa. If the examination proves the proteids sufficient, the opposite course would be pursued. If the fat is in excess causing diarrhea, etc., the proper course would be to cut down or deny altogether the amount of meat, for a meat diet markedly increases the fat in mothers' milk. As a rule milk, that is excessively rich in proteids and fats, is found in women, who live a life of luxury and indolence and have an abundance to eat and live a passive life. Our duty is plain in these cases. Enjoin a more active life and prohibit the wines, salads, condiments, late hours, excitement, etc. On the contrary, less proteids and fats are usually found in hard-working women among the poorer classes and whose food is not of the proper quantity or quality. In this case we will change the diet to plain but proper food, make the husband do the house work and put the mother upon malt in moderate quantites, iron, cinchona, etc. In conclusion, let me state that I have purposely omitted much that is of importance to this subject. My chief endeavor has been to impress upon this society the fact that there are many, many infants needlessly deprived of the maternal breast, in consequence of which they perish directly, through marasmus, or indirectly, through some intercurrent disease, owing to their feeble power of resistance, and that, if we would devote as much time and energy toward keeping them upon the breast milk as we do to the proper solution of the problem of artificial feeding; if we would work assiduously and conscientiously toward this end, we would have in after years happy upturned faces to greet us, whose souls under other conditions would have gone out into the great unknown. If this paper shall be the means of fanning one of those flickering flames of infancy back into the healthy blaze of childhood, I shall be content, and as James Whitcomb Riley would say I need "do nothing else that day but jest set around and feel good." Mother's milk: Truly the milk of human kindness.

SYPHILIS AMONG ALASKAN INDIANS.

By Wm. Gilbert Hay.

Read before the California Academy of Medicine.

Having had occasion recently to visit several Indian villages in southeastern Alaska, I had the opportunity of observing interesting cases of different kinds but I will confine myself in this paper to the subject of syphilis among the natives of that region.

As a rule the Indians do not care for any other than their own "medicine man," and it was only because of having been called to treat the results of a cutting affray which their own "tom-toms" failed to cure that I obtained the entree into Killisnoo society. The original rumpus was caused by the drinking of "Pain-Killer," a tipple that I have not seen on the ordinary American bar. The Indians visit every government vessel and beg for medicine, they generally get bicarbonate of soda. I believe it is simply because they want something for nothing, as they are perfectly indifferent as to what they get or what may be the effect.

My opportunities for studying cases thoroughly were limited, for the vessel I was on was constantly on the move; no histological work could be done, for we had no microscope and the natives are so mortally afraid of a scalpel that I could not procure any specimens. Ten years ago I was in the far north on the Siberian Coast and in the Arctic, and although at that time I had no medical experience the pictures that I saw on the bodies of the Esquimaux have never faded from my mind. Ever since then I have been bewildered during my work in the University of California clinics that such pictures did not repeat themselves among the great number of syphilitics that came for treatment. This last visit to Alaska has opened my eyes. The disease exhibits itself in an exceptional fashion among these people. As a partial explanation: the hygienic condition of their houses is abominable. Civilization has taught them to build the semblance of an American house and the value of a dollar, but that is all. The house contains one room in which they perform all domestic duties—five or more inmates in the room; all the windows are nailed down, and a fire is going nearly all of the time, mostly in a small American stove, and needless to say the atmosphere is stifling. There they squat until it becomes imperative to go fishing or to do other mild work and they wobble out into the cool air, though not very cold, without additional clothing, and the children go bare foot. Many have rheumatism. Why they all have not passes my comprehension. In the second place the Indians take no real treatment for their diseases, contrary to the story books that tell us about marvellous herbs.

Case I. Indian Klootchman, lues, ten or more years duration; never had treatment. Bridge of nose sunken; three scars from old gummata on forehead; buccal cavity and adnexa intact; general adenopathy; both legs and thighs greatly deformed from previous gummata and covered with reniform ulcers size of a palm; ulcers circular, when not reniform, dirty bases, high rolled, indolent edges; left buttocks presents four large spreading ulcers; shagreened and scaling eruption on dorsum of right foot; scales round and ¼ inches in diameter; slight desquamation; nothing on upper extremities; palms, nails, hair and teeth good; native dressing of chewed cedar bark with some red clay on ulcers; had not left the house for seven years. Treatment: hydrogen, peroxid. ung. hydrarg. kal. iodid, 10 grains t. i. d.

Sept 26, repeat treatment: All ulcers healed except one on buttocks. Except for the extent of the disease this case differs in no respect from those seen in this city, but there are others that give food for thought.

Case II. Native, aet., 30 years. Suppurating, shallow cavities, probably broken down gummata on lower and posterior portion of scrotum—in fact the perineum. No superficial scarring, but an inverted edge resembling the retracted nipple in scirrhus of the breast; sinuses leading toward the left testicle, but do not seem to connect; left testicle very large and hard; right tetsicle apparently normal; universal adenopathy; present condition has existed for seven years according to patient's narrative; no previous treatment; history of some skin eruption "years ago."

Case III. Indian about 50 years of age. Similar ailment as preceding case, but both testicles were involved, large and hard, and the sinuses more numerous. Reniform ulcers on the knees both bends of the elbows, anterior surface, and inner sides of both thighs adjoining the crotch. Distribution of ulcers symmetrical.

One objection will be made: Was my diagnosis correct? It is well known that fistulas and ulcerations with involvement of the skin of the scrotum is rare in syphilis while common in encephaloid carcinoma and tuberculous orchitis. But there was no effusion, no large veins over the scrotum, tumor hard and involving both testicles. Further other evidences of lues were present and the therapeutical test was successful.

Incidentally a number of doctors connected with different Government departments as well as casual visitors have said that there is much tuberculosis among the natives. All that I care to say at the present time is that their education has been neglected. One instance will amuse you. At the Presbyterian Mission in Sitka a homeopathic physician showed me a native woman whose entire arm he intended to amputate for a slight luetic periostitis of the fore-arm. She had never taken anti-syphilitic treatment. He was very courteous and I dislike to repeat this, but he was to be assisted by a regular physician from one of the Government vessels who, however, I am pleased to say refused on second thought and some advice. Referring to the two cases last cited, I believe that Unna's classification of such syphilides is correct; something of which I had not been convinced before. They are late tuberous syphilides and not gummata proper.

I will attempt to sum up my observations in Alaska as follows: In about forty cases of lues I did not see one in the condylomatous stage. I did not see a single affection of the mucous membrane. No perforated palates. Eight cases of specific iritis, one with synechia, one completely blind. Many eye cases were reported to me by the Russian storekeeper. Every Indian examined for any trouble whatever had a general adenopathy, including Sigmunds, the epithrochlea, for which I particularly looked on account of the statement once made that their enlargement is pathognomonic of syphilis. This observation holds true of the sailors, some hundred of whom I examined. There was in no case any affection of hair, teeth or nails.

HOSPITAL NOTES.

CALIFORNIA EYE AND EAR HOSPITAL.

By Louis C. Deane, M. D., Surgeon to the Hospital, Etc.

A CASE OF ACUTE RETENTION CYST OF THE SUBMAXILLARY GLAND.

An exceedingly interesting case has just come under my notice. The patient, a young man, 30 years of age, in good health, and the teeth and mouth in excellent condition, presented himself with a swelling at the angle of the jaw about the size of a small hen's egg. He complained that it pained him a great deal at the time, but was worse at meal times, and that the swelling would get much larger after eating and at the end of the day. On palpation the swelling appeared rather fluctuating and seemed quite tender. The rapid development of the swelling together with its increase in size after mastication, suggested the possibility of an obstruction in Wharton's duct. Upon examination the orifice of the duct on that side at the frenum lingue, it appeared a bit more prominent than its neighbor. I succeeded in introducing a small whalebone bougie and as I did so quite a stream of secretion spurted from the duct. I carried the bougie in for about an inch, sounding for a calculus. Feeling none, I withdrew the bougie, and in doing so the small probe pointed and drew out a very small salivary calculus which held the end of the bougie fast at the orifice of the duct. I immediately introduced a probe pointed caniliculous knife into the duct and slit it up for perhaps a quarter of an inch, and picked out the calculus. The swelling at the angle of the jaw subsided immediately and there has been no further trouble.

Redmond Payne.

CAUTERY IN ULCER RODENS OF THE EXTERNAL AUDITORY CANAL.

Cases of epithelioma of the meatus are rather infrequent. The patient, a man of fifty, had had for four years an ulcerated bleeding patch about the size of a nickel on the inferior posterior wall of the meatus, involving in a slight measure the concha. He complained chiefly of slight, though constant hemorrhage from the ear and of pain on attempting to lie on the affected side. Excepting a low ring of infiltration around the ulcerated area, there was no swelling of any part of the ear, and no glandular enlargement. The hearing was, and had been at all times normal. He had consulted a surgeon who had advised a surgical operation, pronouncing the case one of cancer. Before consenting to an operative procedure, the patient had consulted me in the hope of finding relief without the necessity of an operation. I applied a cauterizing paste of chlorid of zinc, the same used in Paget's disease (zinc. chlor., tinct. opii simpl., aa 15.0, amyl. triciti 6.0 aq. dest. 4.0), with the result that within three weeks the ulceration was replaced by a smooth cicatrix, hemorrhage and pain had disappeared and the ear presented a normal appearance. Cautery in its various forms (silver nitrate, zinc chloride, thermo-cautery, etc.) has been almost entirely abandoned in the treatment of cases such as this. Lesser (Diseases of the Skin) protests against this abandonment and thinks that in the early stages of carcinoma of the skin, especially ulcus rodens, cautery deserves more prominence than it has of late years enjoyed.

Robt. D. Cohn.

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SAN FRANCISCO, SEPTEMBER, 1900.

AN OBJECT LESSON IN ETHICS.

An effective lesson in the application of the "Code of Ethics" of the American Medical Association has been offorded by a medical society of our State, where a recreant physician was forced to mend his ways and an eclectic renounced his school and sought a regular degree.

A regular physician, a capable man, on entering practice formed an alliance with an eclectic, consulted with him regularly and became intimate professionally and socially. The local society, of which he was a member, was pledged to uphold the code of ethics and the honor of the profession. The open and flagrant violation by this member of his pledge attracted the attention of the society, and his actions were freely discussed. Meanwhile members of other societies were consulted as to the best course to pursue, and the advice given that no action should be taken; saying that "these ethical questions cannot be satisfactorily dealt with by a society, etc." The conduct of the member, however, was carefully considered and official action determined upon. A motion was offered to expel, which was later amended and the punishment fixed at suspension, until he changed his course and gave definite and positive assurance that he proposed thereafter to adhere to his pledge and to cut away absolutely from this connection. He was personally and officially notified of the action of the society and given to understand explicitly what was expected of him in the future. Fortunately he was a man of sound judgment, realized his error, conformed thereafter to the laws and usages of the society, and in the course of time was reinstated. The triumph of the society did not end here. The eclectic, finding himself alone and unable to secure aid and advice in the hour of need, sought a course in a regular school, obtained his degree and finally became a member of this same society. The regular physician, though he was again received into the fold and extended all the courtesies possible never fully regained his standing with the people and in time located elsewhere. Much good resulted from the firm stand taken by this society, it created a wholesome respect for its obligations, kept others "in the traces" and demonstrated positively that ethical questions can be handled by medical societies, if the members are firm and loyal in their adherence to the code and the principles of integrity that underlie even ordinary dealings in life.

The lesson is worthy of thought, and its application should be invoked in many localities. In small towns where the profession is united suspension in many cases will be effective, but in large cities, where every thing sacred to the profession is constantly and deeply violated, more stringent measures are needed. Expulsion, as usually carried out, means simply advertisement of the expelled, and in the eyes of the public usually marks him as an object of jealously and raises him in their estimation, so morbidly suspicious is the laity of any thing one physician may say or do to another. Expulsion from a medical society brands the expelled as unworthy further association and should carry with it complete ostracism from the medical body; but this injunction unfortunately is never complied with and the result is that such punishment means nothing more than an advertisement and increased popularity. It is evident then either that some other means of reaching these cases must be found or the by-laws of our societies must be stringently enforced to effectively meet those men, who seek unsavory associations and abuse the privileges of the profession, and to give them the freedom and scope they crave without allowing them to degrade others. To this end complete ostracism, fortified by expulsion and a united profession, is the only means. It seems severe, but it alone will be effective and just. In a large center this may seem impossible, but it can be done to so great a degree at least that, as in the above case, the community will in time learn that something is wrong and the offender will be forced to a better expression of his activities or seek encouragement elsewhere. If, however, it may not be so far reaching for good and the complete regeneration of the accused, it will at least deter others from unlawful and unprofessional conduct and raise our standing before the people. Our ethics will not then be the taunt and jeer of a populace, who seemingly cannot realize that these things are done as much for their own as the profession's welfare. Men have been expelled from societies and yet they are in constant communication and consultation in hospitals and private practice with the best physicians. In some cases this may be due to carelessness, it may be indifference; but in most instances it is greed for gold that rings in this want of professional honor. It is a too common and sad a comment on our integrity to see men, commanding high favor sometimes in our midst or in the eyes of the world beyond, in consultation with those, not only of other schools, but quacks, criminals, and illegal practitioners, performing operations for them and often shielding them from crimes that cry to all for mercy. Such actions are not matters of to-day, of yesterday, but of years; they have been going on a long time and are going on now in every city of any size. What will be the outcome? Nothing less than a shattering of all codes, a general demoralization, a dismemberment of all that our fathers loved so well—our honor. The day of the new idea has dawned and that of general and indiscriminate advertising is possibly not far distant. It is alarming to ponder over the frequency and deliberateness with which all covenants of good conduct, be they of the code or common sense, are violated and transgressed without rebuke. Pervading all localities there seems to be an utter indifference and wilful blindness that is criminal to the people whom we are supposed to protect and destructive of all professional self-respect. For a medical society to sit sphinxlike, dumb, silent and indifferent, is an omen of awful portent. Better far that our societies would consist of half the number than tacitly and silently allow the members to become the aiders and abettors of deeds and crimes that degrade and pollute. Every day charges are made against worthy and reputable men by both physicians and laity which are allowed to pass in silence. Is there no voice in our midst to protect us! Where is the light, the faith that made the physician of old so grand? It still inflames the hearts of a few, buried under an indifferent majority. It is not true that all are tainted, that nothing can be done; but it is desperately true that many in power are wofully neglectful of their duty or fear to act. Not alone are these things true and painfully evident in our midst every day, but the whole country seems to be swayed by indifference, prompted no doubt by financial greed. The situation everywhere is becoming dangerous and embarassing to good morals, and no wonder in the face of recent events one exclaimed when speaking on this subject: "Ethics, you have none, we have no confidence in you!"

THE LANE MEDICAL LECTURES.

The Lane Medical Lectures for the year 1900 were delivered by Sir Michael Foster of Cambridge, England. They were especially noticeable for their learning and deep historical research. It was a real treat to follow the maze of thought that brought out the truth, beautifully and tersely told in the language of masters, whose style, so simple and clear, contrasts vividly with the verbosity of our day. The speaker at times was truly eloquent and always clear and strong in his expression. The immediate usefulness and directness of these lectures was hidden to some degree by the amount of historical detail, but they were not supposed to be expositions of modern teaching exclusively such as may be found in our text-books, rather, what should be more impressive to the student, a concise and elegant story of the thought that led up to modern physiology. There is no doubt that this was not what many expected or desired, but it emphasized one thought, deserving of deepest consideration by our physicians, that in order to reach the top, study and thought, dogmatic and independent, is necessary. This suggestion is strikingly shown by the way these master minds approached the truth, so nearly grasped it and yet fell short. This is surely consoling to the worker of to-day, when the most hidden realms of the earth are searched by lens and firebrand for something new, that to the lot of some one of us may fall the fame of having left a thread by which the problems of life in some of their manifestations may yet be solved. While not so practical, these lectures demand as high a rating as their predecessors in this most admirable series. The attendance as usual was neither in keeping with the respect due the fame of the lecturer nor with the generosity of the founder.

TWO MORE CASES OF PLAGUE.

We publish elsewhere a report of cases 14 and 15 of the plague. The cause of death has been verified by several observers and all have obtained the same definite and positive results. The disease has not abated as was hoped or expected and the future is ominous With the exception of Dr. Craig's article in the Pacific Medical Journal and an editorial in the Philadelphia Medical Journal, nothing worthy of consideration has appeared. For the verification of the only point, fairly questioned, the infection of the ship Nippon Maru, we refer our readers to the Public Health Reports, pages 1066 and 1079 for the year 1899.

SOCIETY PROCEEDINGS.

SAN FRANCISCO COUNTY MEDICAL SOCIETY.

Regular Meeting, July 10, 1900.

The President, Dr. E. E. Kelly, in the chair.

Dr. W. N. Sullivan read a paper, "The Prevention of Pulmonary Tuberculosis."

Dr. Clark Burnham presented a paper, "Early Symptoms of Pulmonary Tuberculosis," read by Dr. W. I. Terry.

Dr. G. W. Fuller read a paper, "The Therapy of Pulmonary Tuberculosis." [To be published.]

Drs. Perry and Rosenstirn exhibited a patient who had abdominal tuberculosis.

SARCOMA—COLEY'S FLUID.

Dr. Geo. L. Fitch presented the following case: "The patient is a Chinaman aged 61 years; had been two weeks in the City and County Hospital, where they diagnosed his case as being one of sarcoma of the posterior portion of the superior maxilla. There was also a tumor right in front of the ear and another one on the neck just below the ramus. Each of these tumors were about the size of a small egg. He came to me in March; I watched the case for nearly a month and by the end of that time there was a fungoid mass protruding from the meatus of the right ear, which bled more or less and had an offensive odor. There was also a bloody purulent discharge from the right nostril; the patient could not open his mouth more than a quarter of an inch; there was also great pain all over the right side of the head and in the region of the affected parts. I sent the case to the clinic at the Cooper Medical College, where it was diagnosed as sarcoma, and the patient exhibited to the class of students. At both the City and County Hospital and the Cooper Medical College, the case was considered one of inoperable sarcoma, so I was informed by the patient and his friends. There was no microscopical examination made in the case. I began by injecting one minim of Coley's Fluid in five minims water, into the fungous mass protruding from the right ear, increasing the dose one minim daily; this I repeated almost daily for four or five days. Within ten days the mass in the right ear had almost entirely disappeared the pain had greatly lessened and the patient was very much improved. Before I began these injections the man presented a very anemic appearance and there was marked cachexia. As soon as the mass had disappeared from the ear. I began by injecting the tumor in front of the right ear with from five to ten minum doses of the Coley's Fluid. This I did about twice a week. Within four weeks the tumor in front of the ear had almost disappeared. Then I began on the one under the jaw and that is very much lessened in size. The patient's general condition has improved very greatly, he has but very little pain and can open his mouth about one-half an inch; his appetite is good and he has the appearance of returning health; the discharge from the nostril has very greatly lessened. While this is not a case of complete cure, the improvement is so great as to warrant me in hoping that ultimately the man will be entirelv cured."

Dr. Driesback Smith: "I shall confine my remarks to one point only, and that is a new method of making an early diagnosis of tuberculosis by means of the 'serum test.' Arloing and Courmont, the originators of this test, claim for it, that it is as accurate as the tuberculin test without any of the disastrous results that sometimes occur after the use of tuberculin. Some years ago Prof. Vissman told me that while working in Virchow's labratory he produced acute miliary tuberculosis with tuberculin from Prof. Koch's laboratory. Since that time several cases where tuberculin has been used for diagnostic and curative purposes, the injection has unquestionably hastened the fatal termination of the disease. The test of which I speak depends for its value on the motility of the bacillus—we all know that as ordinarily grown the bacillus is a non-motile organism; but when the germs are grown in glycerine peptone bouillon, from an attenuated culture, and constantly agitated so as to produce homogeneousness, they develop marked motile powers and when brought into contact with the serum of the blood of patients suffering with tuberculosis, they undergo clump formation and cease to be motile in from two to ten hours. The test has one almost fatal drawback, and that is the difficulty of application which prevents its extended use at the present time. The test deserves to have a more thorough trial to see if it fulfills the promises of its originators."

Dr. Cable: "I had expected to hear something new to-night, because we have been in the habit of sending our consumptives from the East over to California for treatment, and I thought from reading the card, which I received calling my attention to the meeting, that I should hear something in regard to the early diagnosis and also in regard to the therapeutics of the treatment. I have heard the hygienic treatment very well given to-night, but nothing else. One man said he used local disinfectants with the spray, disinfecting the throat, mouth and air passages, but as for medicinal treatment I have not heard anything recommended to-night excepting the tuberculin treatment of the man who just spoke and who regards that as worse than useless—as destroying life instead of building it up—and that we have something else equally as good. In Minneapolis where I have been for some time, we have not found any drug that will cure tuberculosis any more than you seem to have found here. Our best men say openly, that they have not found any cure for tuberculosis; that the only thing that can be done is the thing that has so fully been presented here to-night—the hygienic treatment—that and that alone and the building of the system, and thus prevent these bacilli which are supposed to be fighting against life."

Dr. C. G. Kuhlman said: "There are three forms of clinical tuberculosis, namely, the caseous, the miliary and the fibroid; each of which admits of differential diagnosis, treatment and prognosis. While I agree with Dr. Smith that tuberculin is not only unreliable as a test, but dangerous, still I cannot agree with him that the test known as the 'serum reaction' is reliable. The so-called 'Tuberole Bacilli' respond like the so-called 'Typhoid Bacilli' (Widal Reaction) not only to serum in other diseases, but to various inorganic and organic substances. Sanitoria statistics like some surgical statistics, appertain to selected cases and cannot be accepted as reliable. Municipal statistics all over the world show an increase in mortality under so-called modern methods of treatment covering a period of twenty years. All of the authors and some of the speakers, have frequently referred to a pre-tubercular stage; but as none of them have informed us what they understand by that term, the bone of contention, such references are unscientific. The term stands for an undefinable low inherited or acquired physiological condition, which requires considerable clincal experience for its recognition."

Dr. G. H. Evans: "The facts to be gleaned from a perusal of the statistics from the different sanitoriums for the treatment of consumption, and those particularly on this continent, as for example, the Loomis Sanitorium at Liberty, N. Y., where, during the last year, with almost 150 patients, 36 per cent have been apparently cured, and the Muskoka Cottage Sanitorium, where 23 per cent of the cases have been apparently cured, are a complete refutation of the statement that there has been no improvement. The early recognition of pulmonary tuberculosis—that is its recognition in its prebacillary stage—and the early application of intelligent hygienic treatment, serve to make it one of the most curable of chronic diseases. The early diagnostic symptoms have been pretty thoroughly gone over, but there is one which he has not mentioned, the importance of which cannot be emphasized too strongly, and that is an increase of temperature at some period of the day. This may not be an evening temperature; is apt to come on in the early portion of the afternoon between twelve and two o'clock, and can frequently only be detected by keeping a two hour temperature chart for several days. Another valuable means of early diagnosis is sometimes obtained by means of the X Ray, which will oftentimes discover areas of consolidation, particularly when centrally located, before the same can be detected by auscultation or percussion. Where one waits to detect the bacilli in the sputum, and consolidated areas in the lung tissue, he has allowed his case to pass its incipiency and the prospects for cure are not as promising. Dr. Fuller, in his paper on the treatment of tuberculosis, mentions the value of fresh air and nutritious diet, but in my opinion has neglected to mention a factor almost as important. I refer to rest, absolute rest, when the temperature reaches 100° F. or over. There are also some drugs which I have found of value. I have been more fortunate in the effects from the use of creosote than he has. I would not depend upon creosote to the exclusion of other remedies, but in cases where the digestion remains good, creosote, when pushed to large doses, has rendered me signal service in conjunction with the hygienic treatment. Ichthyol also given in large doses, is a drug of considerable value, particularly in cases of mixed infection and more or less profuse expectoration."

Dr. G. W. Davis: "I distinctly feel that our profession has decidedly advanced not only in the more successful treatment of tuberculosis, but all of the infectious diseases. In young persons and in the first and second stages of consumption, I cannot avoid the feeling that a large percentage are cured. As to the prophylaxis, Dr. Sullivan has quite interestingly and fully covered the ground. The signs mentioned in the paper on 'The Early Symptoms of Tuberculosis' are, I think, correct. The successive daily returns of an afternoon's temperature as mentioned by Dr. Evans, is in my experience an important early symptom. I was not pleasantly surprised to hear Dr. Fuller say he had no confidence in creosote; I believe there is no better remedy in the therapy of almost every case of tuberculosis than this. To the point, I will briefly relate a case: A young man more than two years ago, who had not been well for some time, had a severe hemorrhage, in a few months from which he was greatly reduced. Daily afternoon rise of temperature, night sweats and decided emaciation became very marked. The presence of tuberculosis was microscopically revealed. Beside placing the patient in the best possible hygienic condition, the very best, and all the nourishment he could take, he was, in connection with various tonics, given gradually all the creosote his stomach or system would tolerate—it seemed almost to the point of saturation. It was given in a daily spray and on cotton placed near his pillow. In a few weeks improvement had well begun and this continued until he was able to go to Philadelphia. Six months ago he was feeling quite well and strong. I saw a case to-day under the care of an esteemed colleague, who had his patient on the home-out-door treatment of this disease, and he had gained eight pounds in nine days. This shows what properly directed hygienic treatment will do for this destructive malady."

Dr. Julius Rosenstirn: "Although I have to deal with the surgical part of tuberculosis only, I would like to make a few remarks on the paper of therapeutics read and rather unjustly criticized here to-night. If there has been an error made in the long list of remedies and therapeutic methods mentioned, it has been on the side of the too much rather than the too little. We all know the different clinical forms of pulmonary tuberculosis, the various acute and chronic affections, calling each one for special treatment. Nobody would think of taking cases of acute miliary tuberculosis and subject them to experimental climatic excursions but would make them comfortable at home until they died. The other forms of tuberculosis are more amenable to our therapeutic efforts, at least to the curative, whilst the most important, the prophylactic, are necessary for all. For those who have inherited the predisposition for tuberculosis, and for the scrofulous children, a prolonged stay at the sea-shore in a suitably arranged and conducted sanitorium under a strict hygienic regime, is required. Such institutions should be erected by the Government for the children of the poor. The care of the nasal passages has been mentioned here to-night, let me add the recommendation of careful inspection of the tonsils and the teeth as frequent portals of infection. It has been said that there are many methods of lying, the first one is through statistics, but this fault lies not in the science but in the wrong methods and false deductions. The statistics of the German Army, which have been kept for a great number of years and embrace a number of people of nearly the same age, living under similar conditions and nourished with the same kind of food, show that the mortality and morbidity of tuberculosis for this large body of men has for the last two or three decades decreased greatly, due not to the discovery of new remedies but to the intelligent introduction and application of the most improved sanitary measures. This is established beyond any doubt. Whilst we have recognized the ineffectiveness of drugs, with the exception of some few like creosote and ichthyol, both aiding our efforts but not as much as has been proclaimed in their earlier career; the general run of things now, is, that the sanitarium and the open air treatment are the strongholds for the cure of pulmonary tuberculosis in its early stage. They are the ones that have helped to decrease the mortality of this terrible scourge and it seems to be immaterial for the percentage of results whether the patient is in the Silesian mountains or the Riveria, the Swiss Alps or the California desert, but his method of living and feeding in either place, is of the greatest importance."

Dr. W. N. Sullivan: "I would like to comment on the very excellent work which has been done by the Board of Health in the field of prevention of tuberculosis, for although many difficulties have presented themselves in the prosecution of the work, it has won for California the tribute of being reported as having good bovine regulations. I consider this work in the prevention of tuberculosis as of the greatest importance and think that it should occupy a pre-eminent place in prophylactic medicine."

Regular Meeting, August 14, 1900.

ASPHYXIA NEONATORUM—ECLAMPSIA.

President, E. E. Kelly, in the chair.

Dr. Wm. Himmelsbach read a paper, "Asphyxia Neonatorum." [To be published.]

Dr. H. Kreutzmann presented a paper, "The Prevention of Elampsia." [To be published.]

Before the paper was read, Dr. Kreutzmann presented to the Society the following case, exhibiting the kidneys in illustration thereof. "Patient thirty-one years old, one year married; always in perfect health. Between seven and eight months of pregnancy she noticed swelling of hands and feet, edema of the eyelids. Dr. Friedhofer saw her then; she complained of malaise and headache; urine contained much albumen. Some time afterwards the doctor was called at seven A. M., the patient vomiting and suffering pain in the epigastric region. At ten A. M. she was taken with convulsions; after the second she became permanently unconscious; had eight elamptic seizures in all. Patient seen by Dr. Kreutzmann at nine P. M., being in deepest coma; some efforts of labor were noticeable; cervix flattened; os open for finger; baby dead. Venesection and infusion into the vein of 800 cu-cent. of normal salt solution was made. Os dilated, two deep incisions in cervix (Duhrrsen) were made, craniotomy performed and the baby slowly delivered without injury to the mother. She never regained consciousness and died thirty-six hours after delivery, forty-eight hours after first eclamptic seizure. Autopsy was permitted to open abdomen and chest. Besides fatty degeneration of the different organs this remarkable condition of the kidneys was disclosed; the left kidney very large with two ureters joining lower down; the right kidney is cystic. Dr. Luis Nelson was kind enough to prepare a microscopical report of the case."

SAN FRANCISCO SOCIETY OF EYE EAR, NOSE AND THROAT SURGEONS.

June Meeting.

The President, Dr. Henry L. Wagner, in the chair.

The President presented a man, aged 74, who had consulted him, complaining of severe pain, as of a fish-bone, on the left side of the dorsum of the tongue, but nothing was visible to account for it. On the following day there was a little redness. A week later a bluish cyst had formed, which gradually became opalescent, and now, in three weeks, is two cm. long by one cm. wide and still transparent at its center. The President asked the members for a diagnosis, but none was given.

Dr. Redmond Payne presented a case of "Affection of the Cavernous Sinus with Objective Tinnitus." Three years ago an insect got into the right ear, and the patient's efforts to remove it caused bleeding from the ear, with much swelling and pain. Chronic purulent discharge followed, and two months later a clicking sound, which was not synchronous with the pulse, movement of the jaw, or any other movement of the adjacent structures. It would last only a minute or so, but occurred several times a day. Two years later the case was seen by Dr. Powell of Sacramento, who did an ossiculectomy. A few months later the patient was seen by Dr. Geo. H. Powers of this city, who did a simple mastoid operation which failed to relieve an intense pain suffered by patient and referred to the ear. The seat of this pain was then located by Dr. Powers at a point on the posterior wall of the ext. aud. canal., Dr. Powers then chiselled away this part of the wall without relief. On both occasions, while the patient was under the anesthetic, a marked varicose condition of the veins of the right brow and eye-lids was noticed. A right facial paralysis also developed about this time. Some weeks later the patient came under the care of Dr. Payne. He was then in a delirious condition, having been found wandering about town. Temperature 101; pupils widely dilated, and the right papilla hazy, suggesting the beginning of papillitis. There was an unhealed wound of the right mastoid, a purulent discharge from the right ear, the tissues of the right eye-brow swollen, the veins varicose, eye-lid somewhat swollen, but no exophthalmos, and a right facial paralysis as at present. At this time the clicking sound could be heard fifteen feet from the patient. It was occasionally heard in the left ear too, but only a few inches away. The conditons continuing, after several weeks Dr. Payne did a complete Stacke operation, curetting out a lot of softened bone from the apex antrum and attic. The sigmoid sinus was exposed for about one-half an inch. There was no pulsation but as the wall appeared clean and healthy and the jugular vein did not appear coroded the sinus was not laid open. The wound healed very well and the clicking sound has entirely ceased in the right ear but the patient still hears it. At present there is a more or less deep-seated pain in the right ear and over the right brow, a low grade of fever most of the time, but always under 100 degrees, and sometimes 99 degrees. There have been no rigors and no especial sweating. There is a marked and permanent varicose condition of the veins of the right eye-brow, and the retinal veins are very tortuous. Vision R. 20/400. The veins of the brow and retina being branches of the ophthalmic vein, Dr. Payne suggested a possible partial thrombosis of the right cavernous sinus and an established collateral circulation and that perhaps this venous current might be indirectly affected through obstruction of the superior petrosal sinus at the point where it empties to the sigmoid sinus. The question he wished to ask is: Is the trouble the patient now suffers directly or indirectly due to the trouble in the sibmoid sinus, and is an operation upon the latter indicated?

Dr. F. B. Eaton thought the appearance of the retinal veins, the varicose veins, together with the history, indicated thrombosis of the right cavernous sinus. He had seen the peculiar condition of the fundus in a case of his own in a patient with septic endocardtis. He recalled the case of thrombosis of the retinal veins published a number of years ago by Knapp, and thought the appearance of the fundus in this case similar to it.

The President said he considered the appearance unlike that of Knapp's case.,

Dr. Pischel presented a man who had been injured in the right eye by a bit of steel. A skiagraph had been made which failed to show the foreign body. Another one was made by another operator, and Dr. Pischel showed the plate and print, which both showed the foreign body imbedded in the sclerotic and projecting into the vitreous, being about four mm. by three mm. Dr. Pischel explained the failure of the first skiagraph as being the result of the shaking of the room by the turning of the static machine wheels by hand, whereas in the second a motor actuated the machine without vibration. The foreign body was extracted by Dr. Pischel's giant magnet, but much of the retina is detached, though the eye is quieting down.

Dr. Payne presented a specimen of "Glioma of the Optic Nerve" in a girl baby, aged two and one-half years. The eye began to "turn in" a few months after birth, and exophthalmos began about one year later. Pressure upon the globe backward met with resistance. There was slight vision, and the pupil appeared normal in size, but reacted sluggishly. The fundus showed the remnants of papillitis; otherwise everything appeared normal. As the tumor had grown very slowly and there had been no pain, it was thought to be non-malignant. In operating, the external canthus was laid open widely and an attempt made to dissect the tumor out and leave the eye, but this was found impossible, as the tumor was found to be the nerve. The patient made a good recovery, and since the operation four months ago has been in excellent health. The specimen shows that the tumor is confined entirely within the sheath of the nerve; that the nerve tissue is entirely destroyed and its place taken by glia cells; that the tumor has been removed close up to the optic foramen, and it would appear that the glia cells have passed on into the nerve within the cranium. Dr. Payne read the bibliography of similar cases. The prognosis is a question, and Dr. Payne gave the literature of the pathology of similar tumors, and from the contradictory statements, gathered that gliomata of the retina are essentially malignant, often of the retina by metastases of their cells or toxins through the blood current, as well as along the nerve. Also, that primary glioma of other parts of the body, such as the cord and brain, are *benign*, in that they do *not* become *metastatic*, and have no cells or toxins to be conveyed. Hence one would be led to believe that this case, being one of primary glioma of the optic nerve, is benign, and offers a good prognosis. If it were of the retina, though it might *not* be called a carcoma, it would resemble one in all the essentials of malignancy and metastatic developments.

Dr. V. H. Hulen said the specimen was the finest he had ever seen. He had seen the case before operation. In his opinion the prognosis is bad, and would be fatal in some years. He would like to know how the specimen was mounted.

Dr. L. C. Deane said that Dr. Payne had forgotten to mention that while reaching back to divide the nerve it had parted, hence he believed that the tumor extended into the cranial cavity.

Dr. R. D. Cohn said that there is no such historical tissue in the nerve as shown in the specimen, and therefore Dr. Payne is probably correct, as the tumor having originated in the nerve may not be malignant.

Dr. Hulen believed the prognosis bad because, from the descriptions of Dr. Deane and Dr. Payne, the growth extended into the cranial cavity.

Dr. Payne said that as we have seen but few cases it is better to take the experience of those who have. According to the classification of pathologists this tumor is benign.

Dr. Pischel exhibited a Sarcoma of the Choroid

MEDICAL NEWS.

LICENSES GRANTED.

5615. Drake, Norman L., Lebanon, Conn., Med. Dept. Univ. City of New York, March 22, 1891.
5616. Dudley, Hubert W., San Francisco, Central Coll. Phys. & Surg., Ind., March 1, 1899.
5617. Dunsmoor, John M., Los Angeles, Coll. Med. Dept. Univ. of Southern Cal., June 14, 1900.
5618. Dunsmoor, Nannie C., Los Angeles, Coll. Med. Dept. Univ. of Southern Cal., June 14, 1900.
5619. Eckardt, Albrecht Otto, San Jose, Medical Examining Board, Dresden, Germany, June 14, 1889.
5620. Fay, Wilbert Lee, Santa Rosa, Cooper Med. Coll., Cal., June 5, 1900.
5621. Fisher, Arthur Lawrence, San Francisco, John Hopkins Univ. Maryland, June 12, 1900.
5622. French, Edwin P., Mantesano, Wash., Detroit Coll. of Med., Mich., March 1, 1882.
5623. Gregory, Frank Starr, Klamathon, Cooper Med. Coll., Cal., June 5, 1900.
5624. Hall, James S., Los Angeles, Coll. Med. Univ. of Southern Cal., June 14, 1900.
5625. Hayes, Charles A., Los Angeles, Coll. Med. Univ. of Southern Cal., June 14, 1900.
5626. Howard, Joseph Louis, San Francisco, Cooper Med. Coll., Call., June 5, 1900.
5627. Howe, Gadsen Edward, Fort Bragg, Med. Coll. of South Carolina, March 4, 1887.
5628. Irones, Rutherford B., San Francisco, Med. Dept. Univ. of California, May 15, 1900.
5629. James, Joseph William, Sacramento, Cooper Med. Coll., Cal., June 5, 1900.
5630. Joyce, Elizabeth Frances, Sonora, Med. Dept. Univ. of Cal., May 15, 1900.
5631. Kelso, John C., Pasadena, Coll. Med. Univ. of Southern Cal., June 14, 1900.
5632. Krull, Frank, Clarksburg, Cooper Med. Coll., Cal., June 5, 1900.
5633. Lamson, Charles A., Corning, Dartmouth Med. Coll., New Hampshire, June 25, 1891.
5634. Lando, Milton Ellis, San Francisco, Cooper Med. Coll., Cal., June 5, 1900.
5635. Langdon, Samuel Walter Ross, San Francisco, Med. Dept. Univ. of Cal., May 15, 1900.
5636. Lazard, Edmond M., Los Angeles, Coll. Med. Univ. of Southern Cal., June 3, 1897.
5637. Lockard, Lorenzo B. Jr., Pasadena, Med. Dept. Univ. of Pennsylvania, Pa., June 7, 1894.
5638. Long, Stephen M., San Francisco, Albany Med. Coll., N. Y., April 18, 1894.
5639. Maguire, Thomas M., San Francisco, Med. Dept. Univ. of Cal., May 15, 1900.
5640. Mathewson, Carleton, San Francisco, Cooper Med. Coll., Cal., June 5, 1900.
5641. McCombs, Virgil J., Los Angeles, Coll. Med. Univ. of Southern Cal., June 14, 1900.
5642. McRae, Donald M., Oakland, Cooper Med. Coll., Cal., June 5, 1900.
5643. Mutchmor, John T., Alameda, Univ. of Manitoba, Canada, April 7, 1896.
5644. Myers, T. Chalmers, Los Angeles, Coll. Med. Univ. of Southern Cal., June 14, 1900.
5645. Noble, Maud, San Francisco, Cooper Med. Coll. Cal., June 5, 1900.
5646. Noble, Paul B., San Francisco, Cooper Med. Coll. Cal., June 5, 1900.
5647. Osmers, William, San Francisco, Cooper Med. Coll. Cal., June 5, 1900.
5648. Parker, William H., Orange, Med. Dept. Univ. of Buffalo, N. Y., February 21, 1881.
5649. Pope, Saxton Temple, San Francisco, Med. Dept. Univ. of Cal., May 16, 1899.
5650. Pullen, Albert J., Greenfield, Mass., Med. Dept. of South Sewanee, January 14, 1899.
5651. Raynes, Francis Edward, San Francisco, Cooper Med. Coll. Cal., June 5, 1900.
5652. Baker, Charles Reinhold, San Francisco, Cooper Med. Coll. Cal., June 5, 1900.
5653. Reynolds, Frederick W., Los Angeles, Coll. Med. Univ. of Southern Cal., June 14, 1900.
5654. Ruickoldt, Arthur, New Haven, Conn., Univ. of Tena, Germany, June 23, 1865.
5655. Sawyer, Frank Everett, San Francisco, Cooper Med. Coll. Cal., June 5, 1900.
5656. Scaparone, Carlo Gio. Giaioms, San Francisco, Univ. of Turin, Italy, July 19, 1890.
5657. Seeman, Frederick A., Templeton, Rush Med. Coll., Chicago, Ill., May 26, 1897.
5658. Snow, William Freeman, San Francisco, Cooper Med. Coll. Cal., June 5, 1900.
5659. Southworth, Henry Edgar, Stockton, Cooper Med. Coll. Cal., June 5, 1900.
5660. Stile, John, San Francisco, Cooper Med. Coll. Cal., June 5, 1900.
5661. Thompson, Ernest Eugene, Red Bluff, Cooper Med. Coll. Cal., June 5, 1900.
5662. Thompson, Eugenie Gobelle, Stockton, Coll. Phys. & Surg., Kansas City, Mo., April 1, 1897.
5663. Thrasher, Carroll, San Francisco, Cooper Med. Coll. Cal., June 5, 1900.
5664. Watson, Dorothea, San Francisco, Cooper Med. Coll. Cal., June 5, 1900.
5665. Wemple, Emmett L., San Francisco, Med. Dept. Univ. of Cal., May 15, 1900.

5666. Wheat, J. Edgar, Los Angeles, Coll. Med. Univ. of Southern Cal., June 14, 1900.
5667. Wilson, J. E., Los Angeles, Jefferson Med. Coll., Pa., May 15, 1895.
5668. Wisner, Jessie E., San Francisco, Cooper Med. Coll. Cal., June 5, 1900.
5669. Bauer, William John, San Francisco, Med. Dept. State Univ. of Iowa, March 28, 1900.
5670. Chamberlin, Sherman, Clio, Iowa, Barnes Medical College, Mo., March 17, 1896.
5671. Hill, Aymer S. C., Jericho Center, Vt., Med. Dept. Univ. of Vermont, June 30, 1898.
5672. Jackson, Edward Lorne, Hamiota, Can., Univ. of Manitoba, Canada, April 7, 1896.
5672. Kearney, Elizabeth F., Los Angeles, Keokuk Medical College, Ia., March 8, 1892.
5674. La Moree, De Witt M., Portland, Or., Albany Medical College, N. Y., Dec. 22, 1870.
5675. McNaughton James A., Vancouver, B. C., Univ. of Toronto, Canada, March 5, 1893.
5676. Moody, Robert Orton, Pasadena, Med. Dept. Yale Univ., Conn., June 27, 1894.
5677. Mosher, Clelia Duel, Palo Alto, John Hopkins Univ., Baltimore, Md., June 12, 1900.
5678. North, Francis Elbert, San Francisco, Coll. Phys. & Surg., Chicago, Ill., April 18, 1900.
5679. Peck, George William, Elgin, Rush Medical College, Ill., March 25, 1900.
5680. Trappe, Kurt, Los Angeles Univ. Halle, Germany, Aug. 11, 1892; Sup. Board Ex., Berlin, Germany, March 10, 1893.
5681. Girout, Edward David, San Francisco, May 17, 1898.
5682. Laughlin Clyde Briggs, San Francisco, July 24, 1900.
5683. Redington, Vida, Oakland, May 16, 1899.
5684. Beck, Edna L., Berryesa, Cooper Medical College, Cal., June 5, 1900.
5685. Gunn, Francis George, Kelseyville, Cooper Medical College, Cal., June 5, 1900.
5686. Peck, Allan Earle, San Francisco, Cooper Medical College, Cal., June 5, 1900.

CHAS. C. WADSWORTH, M. D.,
Secretary.

MEDICAL ITEMS.

Dr. Emmet Rixford has removed his office and residence to 1400 Van Ness Avenue.

Dr. Charles H. Rosenthal has removed his office to 1025 Sutter Street.

Dr. W. Anderson has removed his office to 1025 Sutter Street.

Dr. Janes has removed his office to 1025 Sutter Street.

Dr. D. A. Hodghead has removed his office to 1025 Sutter Street.

BOOK REVIEWS.

THE ANATOMY OF THE BRAIN. A Text-book for Medical Students. By Richard H. Whitehead, M. D., Professor of Anatomy in the University of North Carolina. Illustrated with Forty-one Engravings. 6¼x9½ inches. Pages, v—96. Extra Vellum Cloth, $1.00, net. The F. A. Davis Co., Publishers, 1914-16 Cherry St., Philadelphia, Pa.

Coincident with the demand for some good text-book in English upon the anatomy of the central nervous system came the works to supply that demand, and one of these volumes is now on our table. Its title is stated above, and it is precisely what the title says it is. It has the advantages of absence of involved and disputed points, brevity, clearness and accuracy. The author exerts his endeavors to assist in the adoption of a uniform nomenclature, by adding in parenthesis the Latin terms adopted and recommended by the German Anatomical Society at its meeting at Basel.

INJURIES TO THE EYE IN THEIR MEDICO-LEGAL ASPECT. By S. Baudry, M. D., Professor in the Faculty of Medicine, University of Lille, France, Etc. Translated from the original by Alfred James Ostheimer, Jr., M. D., of Philadelphia, Pa. Revised and edited by Charles A. Oliver, A. M., M. D., Attending Surgeon to the Wills Eye Hospital; Ophthalmic Surgeon to the Philadelphia Hospital; Member of the American and French Ophthalmological Societies, Etc. With an adaption of the Medico-Legal Chapter to the Courts of the United States of America, by Charles Sinkler, Esq., Member of the Philadelphia Bar. 5⅝x7⅞ inches. Pages, x—161. Extra Cloth, $1.00, net. The F. A. Davis Co., Publishers, 1914-16 Cherry St., Philadelphia, Pa.

This little book deals with a subject that has largely escaped the attention of the profession. The medico-legal aspect of eye injuries is a very important topic, and it has not, as far as we know, been carefully written up by any English author.

The translator and editor have paid special attention to the different relation which the laws of this country bear to such injuries. They have succeeded in giving us a thoroughly instructive and entertaining work that will be appreciated by all who treat eye injuries. The author has devoted some space to the treatment of injuries of the eyes as well as to the medico-legal questions arising from such injuries. The chapter on "Simulated Affections of the Eye" is useful to all physicians. In it the author describes the most practical and successful means of determining whether an eye which presents no visible pathological condition is really blind as is claimed by the malingerer.